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The Function of the Staff in the Administration of Catholic Hospitals[1]

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WHAT is said in this paper will refer only to hospitals owned and conducted by religious orders. There may be hospitals independently owned but conducted by religious orders. With such hospitals this paper has nothing to do.

Speaking in a broad sense, the staff has no function in the administration of a Catholic hospital. A Catholic hospital is owned by the Sisters and they are chargeable with the responsibility of conducting it and of keeping it upon the highest possible plane of physical, moral, and ethical efficiency. They cannot do this if the staff is permitted any controlling voice in the administration of the hospital. Doctors are no different from other men. If anything, they are more inclined to form into cliques in their associations than men of other professions. The formation of such cliques in hospital staffs is, as you all know, not a rare thing. The combination or clique in the majority controls the officers and the committees. Where the staff is permitted to interfere in the administration of the hospital, you very frequently have dissatisfaction and discontent among the minority members of the staff.

Then, too, where the staff is permitted to interfere with the administration of the hospital, they will frequently, or at least occasionally attempt to do things which are obnoxious, if not offensive, to the Sisters in charge. Frequently they will succeed in such attempts because it is human nature to follow the lines of least resistance. In any conflict, it is easier to yield than to fight. In those cases where such attempts of the staff are resisted by the Sisters, friction between the staff and the Sisters is engendered and that harmony which should obtain between the staff and hospital management is destroyed.

There is another evil, and it has possibilities of becoming a grave evil, which can arise from permitting the staff to interfere with the administration of the hospital. Catholic hospitals should lead the way in purging the hospital of the unethical doctor. Occasionally, despite the utmost vigilance, an unethical man will get upon the staff. Occasionally, a man will get upon the staff whose influence is bad upon the internes and the nurses. The medical profession is constantly improving and bettering its moral and ethical tone but unfortunately there are men in the profession who, either because they love money or because they have no right conception of the sacredness of their profession, have no regard for its ethics. Sometimes these men are men of force, ability, and influence in their profession. If a man of that type gets upon your staff, you will find it difficult, indeed, to get his fellow members upon the staff to expel him therefrom. Politics in the staff, or that human trait to follow the line of least resistance, will lead them to complete inaction.

A situation of this kind arose in one of our hospitals in the Middle West only a few years ago. By more or less acquiescence on the part of the management of this hospital in a course of conduct on the part of the staff, the staff was led to believe that it had an active voice in the administration of the hospital. This belief was confirmed by a more or less indifferently drawn set of staff by-laws. The Sisters in charge desired to have a man removed from the staff and laid the matter before the staff for action. No action was taken. When the Sisters in charge forced the resignation of the man in question, certain members of the staff, constituting possibly a majority, very bitterly resented the action of the hospital management and serious disagreements were narrowly averted. The staff members taking this position quite probably had some justification for their point of view because the staff had been permitted to believe that it had the right to interfere in the administration of the hospital. Most of the men on that staff, however, were fair and reasonable and finally appreciated the fact that there was no reason why they should have a voice in the administration of the hospital. They realized that the Sisters owned the hospital, were chargeable with the responsibility of properly operating it and that they should have the exclusive right to manage it. A definite understanding to that effect was reached and since that time, the relations between the staff in that hospital and the Sisters in charge have been most harmonious and pleasant. The difficulty never would have arisen had it been definitely understood that the Sisters had the right, and intended to run their own hospital as they thought best.

[1]Paper read at the Missouri-Kansas Conference of the Catholic Hospital Association, held at Kansas City, Mo., Sept. 1-3, 1925.

Please do not misunderstand me. By what I have said, I do not mean that the staff should receive no consideration from the hospital management. There should always be a medium for the exchange of ideas between the staff and the hospital management. Through this medium, the advice and the point of view of the staff, oftentimes very valuable, can be obtained.

In my opinion, this medium can very properly consist of an executive committee made up in part from the staff and in part from the hospital management. This committee should not consist of more than five members, made up of the Mother or Sister in charge, her consultant, and three members of the staff. The President of the staff should be one of these three. The staff should select the second of the three and the Sister in charge should select the third staff member of the committee. Under this method, the Sisters operating the hospital would always have a majority and would control it. With such a committee properly functioning, the hospital management could always get the advice and point of view of the staff on such matters of hospital administration as the management saw fit to take advice on. Through this committee the point of view and the wishes of the management could readily be communicated to the staff and a close harmony, always desirable, could be obtained and maintained between the staff and the hospital management.

Such administrative policies as affect the professional life of the hospital are of concern to the staff and these very properly should be taken up with this executive committee and their opinion and counsel requested. Where their opinion and counsel are in accordance with Catholic philosophy, with the moral obligations of the hospital, and with professional ethics, they should be given very serious consideration and when possible accepted. If they are not in such accordance, then, of course, they should be rejected. However, it should be definitely understood that the Superior in charge of the hospital has the final decision whether that accords with the opinion and advice of the staff or not.

I cannot close this paper without adverting to a matter that may be somewhat foreign to its subject matter. It is sometimes said that the Sisters in charge of a hospital are lacking in backbone. There is probably some truth in this statement. A disposition to temporize with difficulties and troubles does not make for discipline or harmony or efficiency. I feel that the best way to meet and solve a difficulty is to face it boldly and courageously. Someone has said: "Be sure you are right, and then go ahead." I would paraphrase that by saying, Be sure you are right and then boldly and courageously carry the right into effect. Do not let human respect deter you. Whatever we Religious do for the love of God and for the betterment of the medical profession which means better care of the sick cannot help but call God's blessing upon the work in our institutions.

THE CATHOLIC DAUGHTERS OF AMERICA PAID HOMAGE TO THE CATHOLIC NUNS WHO LOST THEIR LIVES SERVING AS NURSES DURING THE CIVIL WAR, JANUARY 21ST, WHEN THEY PLACED A WREATH ON THE NUN STATUE IN WASHINGTON. IN THE PHOTOGRAPH ON THE LEFT IS RT. REV. W. J. HAFEY, BISHOP OF RALEIGH AND NATIONAL CHAPLAIN OF THE ORGANIZATION.

The Development of the German Hospital

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(Written and Translated for HOSPITAL PROGRESS)

THE true care of the sick, conceived and carried on in a spirit of natural sympathy, exercising charity for the sake of charity without regard to personal advantage or gain, was unknown in the day of heathenism. Everything that has been thought, conjectured and written to the contrary on the subject is devoid of historic proof. Only with the beginning of the victory of Christian thought, which made it a duty to respect the welfare of a fellow creature and to observe the divine command in extending loving care to the weak and needy, was begun the historic record of the higher conception of the care of the sick.

As in the case of most of their church labors, the western countries were inspired to their efforts for the help of the needy and sick by achievements of the Orient. From Constantinople the idea of founding hospitals came to Rome and spread into Italy and France, and in the latter countries, although not fully developed, found its realization through the Benedictine monasteries. The beginnings did not extend beyond the limits of the monastic communities.

The truly charitable spirit of these hospital foundations was expressed in the rule that governed them, namely, that "the sick stand first and must receive attention above all others so that, as we serve Christ, so also we serve them." Upon this principle, embodied in the Benedictine rule, the hospital idea found its origin in the Occident. Special cells, or infirmaries were provided, in which the inmates of the monasteries were to be housed and cared for during periods of illness. The care of the sick was in charge of the so-called *Infirmarius,* also sometimes termed *Magister Infirmorum Hospitalarius.*

In the constitution of the monastery of Hirschau it was provided that only a priest could act as chief nurse, (called *Siechenmeister*). The introduction of the cells for the sick was only a temporary expedient used by the monasteries. As the settlements and villages grew, and the monasteries became more and more the centers of community life, the infirmaries were no longer adequate. They had served their purpose, however, and "as a temporary agency the monastery infirmaries deserve our fullest admiration because they set up standards in keeping with the medical practice of the monks of that period, and they reflected the best practice in the care of the sick and the healing methods of that day."

In place of them, separate houses were built in the vicinity of the monasteries and allied to them. The purpose was not the exclusive care of the sick and convalescent, but the housing of passing travellers and pilgrims as well. Charlemagne was particularly interested in the establishment of these accommodations. Even the Council of Lechtimes, in the year 743, ordered that every monastery be equipped with a hospice (*Herberge*). The Synod of Aix la Chapelle, held in 816, issued a similar order to the convents of women (*Frauenkloster*).

Hospitals and Gardens

An important document in the source material of the history of medieval monastic infirmaries is found in the plan of the monastery of St. Gall, made in the year 820. Here a hospital, with a separate kitchen, bath and blood-letting houses, together with a physician's home, an apothecary shop, and living rooms for the superintendent *(Spitalmeister)* was erected. For the seriously ill, separate rooms were provided, while those afflicted with milder forms of illness were placed in wards. The hospital plant was surrounded by a large garden for the raising of exotic, medicinal plants.

At a somewhat earlier period, the Fridolin monastery with a hospital adjoining was founded at Saeckingen. The hospital at Kreuzlingen, too, historically corroborates the existence of an earlier type of such an institution conducted by monks.

It is a characteristic of the succeeding period that all hospitals primarily served also as hospices for strangers and others in need of shelter. Thus we find

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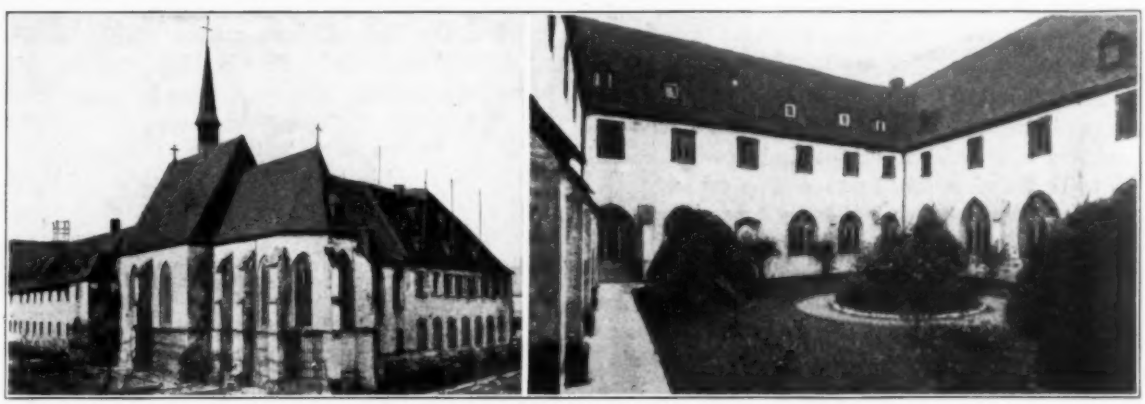


1. ST. NICHOLAS HOSPITAL, BERNCASTEL-CUES, GERMANY.
2. ST. NICHOLAS HOSPITAL, GARDEN VIEW, BERNCASTEL-CUES, GERMANY.

that the refuge of the Abbey of St. Martin in Cologne, founded A. D. 1021, the Holy Ghost Hospital at Freiburg in Breisgau, founded A. D. 1120, and other hospitals, some of which are still in existence, were equipped to render this additional service.

Only the hospitals devoted to the care of lepers excluded the non-patient. These reveal the fact that considerable progress in methods of isolating patients have been made. The number of asylums for lepers *(Leprosorien)*, in the thirteenth century alone was estimated at 19,000. In their development, the Knights of Lazarus *(Lazarusritter)* were most active. The first German leprosy asylum was founded in 1109, at Johannesberg in the Rheingau. In the later middle ages, when syphilis swept as a scourge through Europe, the patients thus afflicted were cared for in the lepers' asylums. Among the isolation institutions of that period were also the so-called "pest" and smallpox houses, usually located outside the city walls.

Since the study and practice of medicine in earlier times was exclusively within the province of the monks, we may safely assert that during this period also it was in their hands. As early as A. D. 550 the celebrated Abbot Cassiodorus, at one time chancellor of Theodoric, in a communication to his brethren, urged the study of the teachings of Hippocrates and Galen, whose achievements in the science of healing had not been excelled up to that day, and who found their greatest admirers and followers in the monasteries of that period and during practically the entire Middle Ages.

Germany had not up to then had a surplus of capable physicians, nor does the literature of medicine of that period reveal any worthy exponents. During nearly the entire course of the Middle Ages the books of Hippocrates and Galen, as well as the works of the Alexandrian medical schools and of the Byzantine scholar, Haese, served as the fountains for all medical knowledge.

Monks were sent to Paris to study medicine. The ablest monks of that time were physicians, thus the Abbot Bertharius, at the close of the ninth century, and more specially Rhabanus Maurus and his celebrated pupil, Walafridus Strabus were physicians.

The convents for women were by no means behind the monasteries. Thus it is told of the Abbess Walburga that she was a highly intellectual and cultured woman, who, like others of her calling, had taken up the study of medicine. One of the most important representatives of the science is Saint Hildegard whose medical writings find recognition even at this time.

Among the secular priests there were many who successfully practiced the art of medicine, if indeed it could at that time have been considered an art. Such records as have come down to us indicate that for centuries the methods of treatment were most primitive in character.

Great value was laid upon medicinal plants *(Arzneikräutern)*, and in the preparation and application of these the monks excelled. The healing herbs were raised in the convent gardens in great volume and variety. Even today the old monastic ruins surrounded by neglected vegetation give evidence of that fact. The medicinal plants now best known were already cultivated in those early days. Thus, Strabus writes in his "Hortulus" that his garden grew twenty-three varieties of medicinal plants.

Influence of the Crusades

The Crusades, which stirred not only the feudal states but also the agencies of the Church into new efforts of service, also gave an entirely new course to the care of the sick. The monasteries were still the centers of charitable work. As a writer remarks "responding to the character of their time, they still bear the hierarchial impress. While the hierarchy, with its clerics and monks, is active, the laity is passive. Service is rendered to them, but they themselves do not serve."

One of the first results of the Crusades in the field of hospital service was the progress of medical science through the introduction of the methods of healing employed by the Arabians and their knowledge of medicines. The first religious orders who fostered hospital labors as their chief work owe their origin in a large measure to the Crusades. The Knights of St. John, the Knights of the Cross, the Knights of St. Lazarus and the Brothers of the Holy Ghost vied with each other in this service.

In an extraordinary manner the Knights of St. John *(Johanniter)* succeeded in the establishment of many hospitals, and through their vows were prompted to render a highly commendable work in the care of the decrepit and poor. The first hospital erected by them in the year 1200, at Halle, was followed by erection of a large number of hospitals in the Empire which served as models in construction and equipment for the succeeding period. It is to these hospitals that numerous hospitals in Germany, particularly in Prussia, owe their beginning.

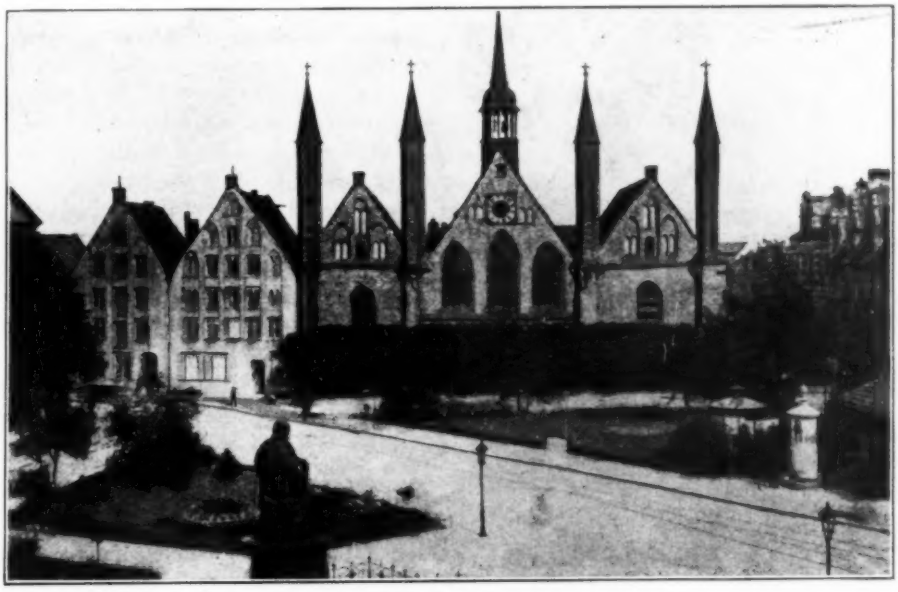
Similar credit must go to the Brothers of St. Anthony *(Antonius-Herren)* and the Knights of Lazarus *(Lazarusritter,)* who between the thirteenth and fourteenth centuries evolved many charitable institutions. And if, during the many wars in the East and the West, the Knights were diverted from their old time vocation, the honor of inaugurating efficient hospital service, and particularly of establishing hospitals which served as models for subsequent effort is clearly theirs.

The reforms of Cluny which spread over the whole Occident, also created lay brotherhoods to whom the care of the sick could be transferred. The orders of Mendicant Friars *(Bettelorden)* took further steps to provide regulations whereby others, outside of the monastery walls and of the regular organizations, could participate in the beneficent work of caring for the sick.

Perhaps the oldest of these Holy Ghost Hospitals is the one at Brandenburg, first mentioned in records of the year 1204. Virchow has mentioned not fewer than 155 Holy Ghost hospitals which existed in Germany during the middle of the fourteenth century. Accord-

ing to records kept in the Cathedral of Freising *(Freisinger Domkapitel)* dated A. D. 1283, the Brotherhood controlled 300 hospitals.

Among the first hospitals of this character must be mentioned the one at Marburg founded by Saint Elizabeth of Thueringen, and protected by the dethroned Duchesse *(Landgraefin)* and the Tertiary Sisters *(Tertiarierinnen)*. Besides, there was the Holy Ghost Hospital at Frankfort-on-the-Main which was managed by a brotherhood and in 1317 turned over to the municipality, and many others might be likewise enumerated.



HOLY GHOST HOSPITAL, LUBECK, GERMANY.

The institutions created by the mendicant friars and the nuns led to the transition period in which hospitals were turned over to the civic authorities, and it was in this period that the Brotherhood of the Holy Ghost spread its activities. Its highest point of service was reached between the twelfth and thirteenth centuries. To this period, too, must be credited most of the hospitals subsequently established, although many of them were not immediately founded by the Holy Ghost Brotherhood. This applies particularly to northern Germany where most of the hospitals were primarily established as municipal undertakings.

In South Germany, however, the hospitals owed their establishment directly to the brotherhood, as for instance the hospitals of Memmingen, Wimpfen, Nuremberg, Landshut, Kaufbeuren, Regensburg, Passau, etc. But, North Germany also owes some of its hospitals to the brotherhood, as for instance the Holy Ghost hospitals in Hamburg, Kiel, Luebeck, Fulda, Cologne, etc.

A Marvelous Service

Scarcely another religious order of the Middle Ages wielded a greater influence in charity work, as expressed in hospital service, and through its rigid discipline gave a greater impetus to that service, than did the Holy Ghost Brotherhood.

With the close of the Thirteenth Century a new period is introduced and the municipal hospital comes into the foreground. The convents and religious foundations which had led as centers of culture and charity were little by little succeeded by institutions erected by the municipalities. The former order of things gradually declined and the brotherhoods and guilds gained a tremendous expansion.

The cities began to assert their pride in large and attractive hospitals, and the guilds supplied the beds for their sick members. The number of hospitals now grew year by year. Hospitals which had been long established were taken over by the municipal authorities, as was, for instance, the Holy Ghost Hospital at Frankfort-on-the-Main.

The period between 1250 and 1360 records great activity in the establishment of city hospitals, so that even the smaller communities operated hospitals of their own. Thus the hospitals of Hamburg are mentioned for the first time in 1296. The hospitals of Luebeck (A. D. 1324), Hannover (A. D. 1256), Heiligenstadt (A. D. 1378), Duderstadt (A. D. 1398), owe their origin to the same period.

In the selection of sites and plans a due regard for sanitation was observed so far as this was understood and was considered expedient. Sites outside of city walls and along rivers were generally favored because cleanliness was considered more possible there and because such locations were accessible day and night to the traveller.

Frequently hospitals were surrounded by peculiar conditions. The hospital at Ulm, for instance, consti-

tuted a separate parish, and without its authority no chapel or auditorium could be erected in a given territory. The church enjoyed the right of free burials which meant that any deceased might be buried in its cemetery, except political fugitives and usurers. The hospital, too, enjoyed privileges against public interference, such as were accorded to the churches and cemeteries of Koenigsburg and the Koenigspfalz. Attacks upon the hospitals were punishable by excommunication. Similar privileges and protection were enjoyed by the Hospital of the Holy Ghost at Freiburg in Breisgau.

MOTHER HOUSE OF THE GRAY SISTERS, NIESSE, GERMANY.

So long as the hospitals were under the control of the Church it became the duty of its representatives to look also after the spiritual welfare of the patients. A regulation of the Holy Ghost Brotherhood provided that the patient should receive the Sacraments immediately upon admittance to the hospital and the Council of Lateran in the year 1215, urges the doctors "to remind the patients to call in the spiritual physician. If their spiritual welfare is provided for, the physical recovery will proceed more satisfactorily."

The life and activities of the patients were subject to certain regulations. The hospital of Ulm, for instance, sought to regulate the personal conduct and religious life of its inmates. The conditions of admission were most liberal. The hospital was an institution for all the poor and sick, for the virtuous and the wicked, for the clergy and the laity. The poor were provided with shelter and food. What they did not eat they were allowed to sell. Every one could work and spin for himself if his time was not required by the hospital. Patients and pilgrims were kept until they had fully recovered. If a patient had been in the hospital for one year, and proved his poverty, he could remain for life. Whoever left the hospital voluntarily was given the belongings he had brought with him. The hospital regulations were publicly announced on holiday occasions.

Maintaining Charity Patients

In many hospitals, wealthy foundations and large guilds made it possible for a considerable number of patients to be admitted free of charge. Thus, the organization documents of the charity hospital of St. Nicholas at Cues clearly provides that: "We declare and herewith order that the St. Nicholas Hospital, organized, constructed and managed by us, shall always maintain without cost to themselves at least thirty-three patients to correspond with the number of years that Christ our Savior spent on earth."

After the cities had established their hospitals they were concerned to retain their control over them. The first consequence of this policy was that the religious orders no longer directed the management of the institutions, but were merely allowed to work under the city officials in the capacity of assistants. The hospital superintendent and managers were placed directly under the municipal authorities so that the final control remained in the hands of the latter.

At the Holy Ghost Hospital of Frankfort-on-the-Main, the care of the sick was entrusted to female nurses who were directed by a "Mother." There was no hospital physician as such, but the city physician was obliged to attend the patients free of charge. Moreover hospital physicians as such were seldom met with because the medical services were usually in the hands of the clergy connected with the hospitals.

This function remained with the clergy for many years, and while the Council of 1215 forbade all surgical operations (burning and cutting), it followed that owing to the accepted methods of treatment of that period, the order was rarely enforced.

With the passing of time the hospitals lost much of their character as such and gradually developed into general homes of refuge *(Pfruendnerhaeuser)*. The sick were crowded out by those who were well. The institutions became the homes of un-attached, aged, and incapacitated men and women. Life in the middle ages was more uncertain and changeable than it is today, and hence less prosperous.

Added to the uncertainty of life came the characteristic urge of the medieval peoples to seek peace and quiet where the spiritual ends of life might be pursued under favorable surroundings. It became customary for people to negotiate or buy a place in a hospital, as a permanent refuge, for the two-fold object named, in which to spend their declining years. Not infrequently incorrigibles and convicts were provided with homes in the hospitals, so that gradually the old time hospitals served as the community refuges for all sorts of derelicts and others who shunned the light of day.

This relinquishment of the care of the sick, caused by the changes enumerated, shattered the charitable efforts of the hospitals to a tremendous degree, and further hastened their decline through the spiritual and numerical decline of the brotherhoods and sisterhoods, who had formerly attended the patients. This decline reached its lowest depth during the Sixteenth Century.

"The institution remains, but love has flown," writes Uhlhorn, "Now, as before, the institution performs its work, but it is performed in an official manner, in fact, it is performed mechanically."

The Reformation, which found the hospitals in a deplorable state, only increased their difficulties. Naturally in the Protestant regions the conditions were worse than they were in the Catholic centers. The new teachings of the Reformers deemed all charitable effort superfluous. "The hospitals which have remained in Protestant territory, with but few exceptions, are poorly conducted and no improvements have been engaged in." So says an authority.

Comprehensive plans for reorganization failed, owing to the financial ruin which the Thirty Years' War brought upon the several states and cities of Germany and which necessarily restrained the charitable efforts of the people. The Church, too, was prevented, owing to the confiscation of its monasteries and religious foundations, from fostering charitable work as it had done heretofore. Thus, it was that during the confusion which marked the seventeenth and eighteenth centuries, the institutions for the care of the sick became negligible.

Period of Reorganization

With the beginning of the eighteenth century the several European states began to reorganize their institutions for the care of the poor. While the Protestant countries developed the public or community institutions, it is found that in the Catholic sections of Germany the hospital remained, after the pattern of Catholic countries outside of Germany, the center for the care of the poor. The church expended the income of its institutions, while the civil authorities shared in the voluntary subscriptions as well as in the hospital administration and control.

The result was that the hospitals became more than ever the hospices of the homeless, of mendicants, orphans, convicts, and those who in any manner had a claim upon society for support. The character of the hospitals was finally changed so much that patients preferred to be treated in private homes.

A statement made by Dr. Horn in the middle of the Eighteenth Century in reporting on the Charité Hospital of Berlin becomes significant. He said: "The Charité Hospital was, during the time I served in the same, in hands of incompetent male and female nurses. This fact is established beyond a doubt, admitted by the civil authorities, publicly deplored by the physicians, known to the officials of the institution, and corroborated by many thousands of patients."

Hospital conditions were rendered even more unfavorable during the latter part of the Eighteenth Century, when the socalled reform movement drove the religious orders altogether out of the hospitals. In Bavaria, when Ludwig I ascended the throne, there were still twenty-seven convents, but not a single hospital connected with them. The secular nurses, who had displaced the religious nurses, were unable, notwithstanding the willingness of the authorities, to encourage improvement, to raise the standards of the service.

Incompetent Nurses

"Obviously most of the difficulties which attend the public hospital service," said Dr. Simon von Haeberl, chief physician *(Obermedicinalrat)*, in discussing the situation, "are attributable to the nurses and attendants. One is compelled, as chance requires, to assign male nurses for female patients, and to employ individuals as nurses who are not wanted in other occupations. They come without training, without interest for the institution, and without sympathy and feeling for the patient. They make the lot of the patient more unbearable through their coarse and clumsy manner, their frequent mistakes, and their selfish and domineering behavior. Their discharge is following only by the employment of individuals equally incompetent and similarly useless."

So it becomes evident that while Italy, France, and Spain made constant progress in humanitarian effort and hospital life, the German hospital of the Eighteenth Century remained meagerly equipped, in charge of untrained and incompetent male and female nurses, an institution into which patients had to be taken forcibly.

When in the "twenties" of the Nineteenth Century the religious orders, devoted to the care of the sick, were permitted to return to Germany, and when peace followed the War of Liberation *(Freiheitskrieg)*, the state once more turned its attention to the care of the sick and dependent. With the enactment of wise social laws, together with the marvellous achievements of medical science in Germany, the modern German hospital found its best impulse and ultimate success.

THE WORD "HOSPITAL"

The origin of words is very significant. "Hospital" comes from the Latin "hospes" which means "a guest." It has the same origin as those charming words "hospitable" and "hospitality." Ponder on this a moment. It means that the patient is a guest, not a "case" nor a specimen, nor anything else but the object of whole-hearted hospitality, by hospitable and kindly hospital folk. "Host" probably comes from the same charming source. So every hospital worker is a host or a hostess to every patient in the hospital.

—E. F. G.

Hospital Care of Workmen's Compensation Cases

J. W. Duncan, M.D., Associate Attending Surgeon, Creighton Memorial, St. Joseph's Hospital, Omaha, Nebr.

AS the population of our country becomes more and more urban and more highly industrialized and as the wage earning class increases in proportion each year, the number of people who come under the provisions of Workmen's Compensation acts rapidly multiplies. In the last decade or decade and one-half there has come about a changed attitude of employer towards his injured employee. Now-a-days there is no disposition to escape the responsibility of caring for the disabled workman and the expense of re-habilitation is recognized as one properly to be borne and is set aside as part of the cost of production. This is, in part, due to a more humanitarian viewpoint I believe, and in part due to limitation of immigration and a considerable shortage of labor. Besides, more than three-fourths of the states (the exceptions representing those largely agricultural and with few hazardous industries) have compensation laws providing indemnity and medical care for the injured person. Very large corporations often establish hospitals of their own to care for their injured employees but the majority of injured workers are still cared for in the wards of general hospitals.

The great majority of industrial accidents are, of course, of a minor character and do not demand hospitalization. The proportion depends on the character of the industry and the efforts made to prevent accidents. Compensation accident cases are advantageous from the hospital standpoint for several reasons. Most of the injured are healthy men of vigorous, adult age. They require, with some exceptions, only ordinary nursing care and are often ambulatory, active, and disposed to ask little of the nursing staff. Unreasonable demands for service can be met with the statement that no provision has been made for it in the contract under which the patient was admitted. Employers or insurance companies are usually willing to provide special nursing and appliances for the re-habilitation of employees, for, in the long run, it is money well spent since adequate care reduces the terminal disability for which industry must pay.

It is to be remembered, however, that the compensation laws of a great number of states provide for a limit to be spent for hospital and nursing care. This is often ridiculously low; in some states the maximum is $200.00. In compound fractures or those requiring open reduction this amount is often entirely inadequate. After the stipulated amount is expended, liability on the part of the employers or his insurance carrier no longer exists. The hospital, for humanitarian reasons, cannot refuse further care. In these cases the industry shirks its plain duty and shifts upon the agencies supporting the hospital the burdens it should rightfully bear.

Organized effort by those persons and institutions devoted to the care of the injured should be made to remove this limit in states where it exists. Coincidentally every effort should be made to keep within reasonable bounds the medical expense in compensation cases and to shorten as much as is safe and possible the hospitalization. Complaint is often made by insurance companies of what seem unreasonable expenditures for medical care. In at least one state last year this amounted to slightly more than the entire amount received by injured employees for compensation.

It is the writer's opinion that much money is wasted in the hospitalization and long continued treatment of the traumatic hysteric or, as he is more commonly but less properly designated, the traumatic neurasthenic. Never to my knowledge has the hysteric been in the slightest degree benefited by any form of treatment except the settlement of pending litigation and final adjustment of his claim. Such a problem is a legal one and not strictly medical, as is shown by the specific remedy.

Compensation cases offer opportunity for the legitimate development of the physiotherapy department of a hospital. To date, physical agencies, if properly employed, have demonstrated their value in stimulating repair and hastening functional recovery in a great variety of skeletal and soft tissue injuries. Their worth in visceral degenerations and acute non-surgical infections remains to be determined. The hospital that does not now have at least the minimum of physiotherapy apparatus, for use in treating acute traumatic conditions and their sequelae, will soon be badly outdistanced.

The proper handling of industrial surgery demands constant and readily available intern and nurse service. The surgery and the x-ray laboratory and the splint room must always be immediately accessible and ready to render service. Ordinary standard splints should be a part of the equipment of every well organized hospital, but the writer has never thought it part of a hospital's duty to provide highly specialized, expensive, and unusual splints for cases, unless proper provision be made for their purchase. Splints worn by the patient on his discharge from the hospital should be charged for, and credited when they are returned.

DISPENSARY NOTES FROM CHINA
(Taken from "Franciscans in China")

A new dispensary was opened by Miss Hurbrich in the village of Da-Wan, which is about 6 li outside of Wuchang. The village is entirely pagan. The name of St. Joseph's Dispensary has spread even to this village and two delegations came to Miss Hubrich asking her to begin a dispensary in this village. The pagans offered her a house of two rooms; one for the dispensary, and one for the purpose of giving instructions. Many expressed their desire to become Catholics.

Two little waifs were picked up this month. One was found crying for all it was worth in front of the dispensary gate; the other was taken away from its mother who wanted to strangle it. Rather than see the infant killed, neighbors assured the mother that they knew of a person who would take good care of it, and accordingly brought it to Miss Hubrich. Such is the influence of Christian charity.

The Nurse and Air and Exercise

James J. Walsh, M.D.

IF the nurse is to prove the almost inexhaustible source of favorable suggestion and the forestaller of worries for her patients that she ought to be, she must herself be constantly in as cheery and favorable a mental state as possible. She must be able to throw off her own worries and anxieties and dispel her moods effectively. She will suffer from them as all mortals do, but she will show no sign of them and should seem to be the happiest of beings. This seems a good deal to ask yet actors and actresses do it constantly in the course of their professional duties for no higher motive than to amuse people while the nurse has the potent ideal of saving her patient from suffering.

To be successful in this it is extremely important that the nurse should keep herself in just as good physical condition as she can so that her mind may be free from worries and obsessions and dreads. The most important factor for this is to get out into the air just as much as is possible in connection with her duties. The people who worry and stew about things are those who are too much in the house. Nothing blows the cobwebs of anxiety out of the mind like fresh air, especially in cool weather. A walk of a couple of miles on a bracing cold day will help one to solve one's problems and keep one from worrying about little things more than anything else that I know.

Worry means, when you look up its root in the old Anglo-Saxon, to take by the throat as a dog worries sheep. This undoubtedly has reference to the feeling of tightness of the throat that goes with worry whenever it is deep and which prevents people from breathing properly. There is almost literally a choking sensation and the "ball in the throat" which comes with hysteria is related to it. Undoubtedly it limits the activity of the lungs and this prevents proper oxygenation and disturbs the physical feelings. A state of mental despondency then becomes one of physical depression and lowered metabolism. People need to have more oxygen supplied to them so that the very best thing for worry is to get out in the air and being outside in any sort of weather will have a definite heartening effect.

A great many people seem to think that if the weather is damp, above all if it is raining or if it is moist under foot or if it is blowing and particularly if it is snowing, that it is better not to go out. With our modern wraps and raincoats and rubber foot protection there is no reason in the world for thinking that it is necessary to stay in the house just because it happens to be drizzling a little or even if it is raining pretty hard. An umbrella and a raincoat and rubbers will be ample protection. Some people think that it is quite excuse enought for them to stay in the house if it has rained to any considerable extent earlier in the day, but of course this is only an excuse and not a real reason for staying in. Some people have a holy horror of getting their feet wet and this is quite justified if you go out for only a few minutes and then come in to sit around with wet feet on a chilly damp day that has no drying atmosphere. Above all if you get your feet wet and then sit around in a railroad car or a trolley car or elevated for an hour or two in wet shoes there is danger of disturbing the circulation and producing congestion. But if you keep moving actively there is almost no danger from this.

During the war our young soldiers found that wet feet meant nothing to them so long as they were active and occupied, and many of them were in much better health than they had ever been at home in spite of the inevitable wet feet of Flanders' fields. One young fellow wrote home to his mother in Boston who had brought him up very delicately and saw that he wore rubbers whenever he went out if it was at all threatening, and who had cultivated in him a proper holy horror of damp feet: "I have not slept in a dry bed for three months, I have not had dry feet any time for the last three weeks, but I never felt so fit in my life."

As for a snowstorm, nothing takes the blue devils out of one so well as to have a good long walk under a brisk fall of snow, provided, of course, it is not half raining and sloppily melting under foot as it falls. In this matter of the dread of dampness a great change has come over the habits of humanity during recent years.

THE WORD "NURSE"

"Nurse" comes to us from the Latin by way of the French and it springs from "nutrio" which means "I feed." Thus it was at first applied to the office of mothers when they feed their children. Thence it came to have the general sense of caring for the helpless and the dependent. By the very name of her profession, the nurse should have in her heart the unselfish and devoted love of a mother, pure, selfless, self-sacrificing, swift to service, sedulous in learning, accurate in doing, patient in suffering. For it is the noble office of a nurse to mother poor suffering humanity in its hour of extremest need and most piteous dependence. —*E. F. G.*

Rubbers are a comparatively modern invention. Rubber clothing is only a little more than a generation old. The umbrella was invented only about a hundred years ago and the first man who dared to carry one on a London street was the subject of ridicule at first and then came near being mobbed by the crowd for presuming to prevent the rain from raining on the just and the unjust alike.

A little rain or snow should not keep people from taking their daily constitutional walk. Walking in a snow storm is thoroughly bracing and nothing gives one a better sense of the joy of living than the white, immaculate landscape as the snow comes down and the extra play of muscles that is needed in order to get through the snow. Of course mere cold should never be an excuse for remaining indoors during the hours off, no matter how cold it may be. Half an hour's brisk walk in a temperature below zero will set the blood coursing through the veins, relieve one of the tired feelings of the past twenty-four hours, give one an appetite for the next meal better than any tonic in the pharmacopeia and make one ready to enjoy a good night's rest to wake refreshed better than any soporific that we have.

It is often assumed that we are ever so much healthier than people were in the old time, mainly because we do not expose ourselves so much to the elements but there is very serious doubt whether any such conclusion is justified. Coughs and colds are at least as common, probably even more common than they used to be, because they are contagious and are caught in our crowded cars and halls and theatres much more than before. The contagious diseases like typhoid fever and smallpox which used to be important factors in mortality and morbidity are not worse in rainy weather and have nothing to do with dampness. What has increased in modern times are the neuroses, that is the nervous affections of various kinds due to functional disturbances of important organs. They occur particularly among people who do not get outside as much as they should, and undoubtedly the dread of damp weather and of dampness generally has much to do with this condition.

Nurses are sometimes inclined to think that any sort of diversion will do during their hours off duty. Undoubtedly diversion is required but it is not nearly so important as fresh air. Hours off ought not to be spent shut up in a room, even though there may be pleasant friends in it, unless there have been several full hours at least in the open air. The nurse is likely as a rule to take more rest than is good for her, rather than too little. No healthy person should take more than eight hours out of the twenty-four for rest in bed unless there is some very special reason for it.

Some form of exercise will probably do more to relieve tired sensations and above all to get one over that "played out" feeling than any amount of rest or even diversion. A game of tennis, a game of golf, an hour's skating in the winter time, a brisk walk (not a dawdling little excusion without any objective and stopping here and there to see things along the way) will set the circulation going and do more to relieve tired feelings than anything else. This is particularly important if the nurse has to stand up most of the day. Her feet get so tired while standing around that she thinks she must rest. A brisk walk that will send the blood coursing through those tired feet will do more to relieve them than all the rest she could take. I have often tried this with shop women and with floorwalkers in the department stores, with teachers, waiters, and others similarly employed, and I know how much benefit they often derived from a two mile walk at a time when they thought that they were entirely too tired to do any walking.

Strange as it may seem, physicians and nurses are more likely, unless they have deliberately formed good habits in the matter, to be neglectful with regard to the amount of air that they get during their daily life than most other people. It is just a case of forming habits that are unfortunate. Physicians, especially as they grow older and become more busy with office and hospital practice, are likely to be a good part of the day inside, and this is true of nurses to an even greater degree. This confinement within doors makes their skin surface sensitive to changes of air, so without quite realizing it they are prone to permit the outdoor air to get into their rooms less than is good for them. Great improvement has come in this matter in recent years, but there still remains ever so much room for further improvement.

It is extremely necessary for good health and especially for nervous equilibrium that there should be an abundance of air both within and without the living quarters. Except in extremely cold weather people should not sleep in a room that has not some aperture for the admission of fresh air directly from outside. In order to sleep in comfort in colder weather it may be necessary to be well covered, but it is much better to get extra blankets than to sleep in a room that is artificially heated and that has no direct ingress of air.

What is true during the night should also be true during the day. Our windows are, as a rule, so constructed that sufficient cool air will, in cold weather, find its way in along the sashes, but in cases where they are constructed nearly air tight there should be a slanting piece of glass inserted at the foot of the window and the window raised slightly. This will prevent a direct current of air and will divert the fresh incoming air upwards and yet keep the room thoroughly ventilated.

Of course in this matter the nurse will have to follow the physician's directions so as to protect the patient properly, but in case it is necessary to keep windows closed she can secure breaths of fresh air for herself rather frequently in her journeys to and from the sick room. She should take every opportunity possible to get into the air. One does not "catch cold" from exposure in spite of old traditions to the contrary.

Physicians in recent years are likely to insist on there being a direct ingress of air into the sick room and nurses should be careful to fulfill their directions implicitly. Often there may be some opposition on the part of the family and especially of older folks to the temperature that prevails in the sick room in colder weather as the result of direct ventilation and the nurse must use all her tact to secure it.

New York City's experience with children suffering from tuberculosis of the bone was extremely interesting in what concerns direct ventilation. The children, many of whom had been invalids in hospitals for several years, were sent down to Sea Breeze for the winter months. This institution had been built originally as a summer home for children and was scarcely intended for winter occupation. Down there, though the air was blowing freely from the sea, the windows were kept open. Patients who had failed to be bettered by the best hospital care and the finest surgical skill in the city improved at once under this fresh air treatment. Starting pains at night were extremely common among these patients and proved very disturbing to the children and their nurses during their stay in the city hospitals. These ceased within ten days as a rule after the transfer of the patient to the cooler quarters at Sea Breeze. Nurses had to wear their caps and doctors wore their hats and overcoats and gloves because the temperature was down to fifty or even lower in the wards but the delicate, ailing children thrived on it as they had not under the most meticulous care in hospitals in temperatures that were kept artificially up to seventy degrees or more.

There is an unfortunate tendency at the present time to keep temperatures in living rooms entirely too high. Sixty-five degrees Fahrenheit used to be considered a healthy temperature for houses and even for hospital wards, but now people are inclined to think this quite low and to feel shivery in it. It is not unusual to find rooms in apartment houses at 75° F. This is entirely too warm and makes people very sensitive, that is to say, whenever they have any discomfort it is emphasized at least, if not multiplied, by this artificial warmth by which they are surrounded. Such a temperature makes those who have to stay in it very tired; there is nothing like living in a high temperature to give people that tired feeling. Prolonged stay in it makes it very much more difficult for even the well to go on with their work with reasonable energy, and it tends to produce a feeling of exhaustion in the ailing which is rather hard to overcome.

Experiments made on university students have shown that if they are kept in an absolutely equable temperature at 70° F. or slightly higher, at the end of some two hours they are sleepy and almost incapable of successfully going on with their studies. A sense of mental tiredness develops which makes them easily susceptible to the suggestion that study has brought on an exhausted state of mind. They come to the feeling that if they try to go on with their work it might even give rise to serious mental exhaustion from which recovery would not readily take place. All that is necessary to obviate these disturbing feelings is to admit some cool air to the room at intervals or even to set a fan going.

This serves to blow the air away from people who are at rest and thus enables them to get rid of some of their heat, which has a definite tendency to accumulate and give feverish feelings. Air is a non-conductor of heat and if the layer of air near a person becomes warm and the room is so still that it is not removed occasionally, there is a tendency to the accumulation of heat within the body that renders one distinctly uncomfortable. Hence comes the necessity for ventilation or some stirring of the air in the room by fans or other means and above all for a direct access of fresh air from outside.

Most of the older notions, that the feeling of exhaustion that came over people when confined in a close room was due to poor ventilation and impurities in the air, are now being abandoned almost completely. It is not the accumulation of carbon dioxide in the air, nor the presence of emanations from the lungs of animals or human beings in a closed room that makes it stifling, but the failure of all opportunity for the diffusion of heat from the body. It is not a chemical problem as used to be thought but a physical problem—that of the disturbance of heat regulation. The holocaust of the Black Hole of Calcutta was a physical, not a chemical tragedy, a heat problem, not a breath problem. Hence the necessity for cool fresh air at intervals, always of course with the approval of the physicians, for there are cases where cool air might induce internal congestions and consequent exacerbations of bacterial infections. Cool air must always be looked upon as a desideratum to be secured just as far as possible.

Tuberculous patients, who sit outside even in very cold weather, do not suffer from pleurisies and other complications involving discomfort nearly so often as those who are housed more carefully. As a matter of fact, a good many patients have old foci of tuberculosis in their lungs which light up rather easily when the patient is run down by some other affection that keeps him in bed, or in case he has to go through the shock of an operation. It is this, and not any drafts of air in the hospital that produce these complications. All the "chills" from which patients used to suffer in the old time hospitals, were attributed to colds caught from drafts and from the admission of fresh air. Almost needless to say these were due to direct microbic infection of the tissues and not at all to "catching cold," though that was the favorite explanation of them and indeed still is for many people who have not kept abreast of modern medical advance.

The knowledge of recently obtained information will convince nurses of the necessity of maintaining open windows and, above all, will enable them gently

and tactfully to persuade the family to obey the physician's orders as regards the maintenance of open windows at all times. His orders, however, must be followed in the sick room with the most absolute fidelity, though the nurse in her own room should be sure to keep the ventilation as good as possible. This will do more to keep her nerves in good condition, help her to sleep well and restfully and give her more appetite for the morning meal than anything else. Above all, if you want to wake refreshed from sleep, you must have fresh air in your sleeping apartment and must have been out in the open for a prolonged period the day before.

Fresh air within the house is extremely important, but fresh air secured outside the house is even more necessary for health and good feeling and cheerfulness. The nurse should be sure to take every opportunity that she can to be outside. Her hours off duty should, to a great extent, as we have said be spent outside. Every human being ought to be out in the open at the very least two hours every day and it would be ideal if from three to four hours could be spent outside. A good deal of this time should be spent in walking. The lesson for physicians in New York in this matter was the old age reached by physicians who walked a good deal in their younger and middle life. My very dear friend Dr. Emmet, who did so much for the Woman's Hospital in New York, had at the age of forty-five a practice of $50,000.00 a year, when there were nothing like the big fees that there are at the present time. Yet he never kept a carriage, but walked to his practice. He lived to be ninety-three. Another man who walked very much in his younger years and rode very little and who never took a vacation until he was past sixty was Dr. Stephen Smith, who lived to be just four months short of a hundred years. Dr. Jacobi, who lived to be nearly ninety was another one of the very hard workers in medicine who spent a good deal of time in the air, walked particularly in his younger years and was one of the most faithful attendants at medical society meetings that we had in New York. These meetings were held in the evening and attendance at them meant that he had to get out after dinner and not sit quietly beside the fire, presumably enjoying the rest which so many physicians feel they need after a long day's work. It is very easy for physicians or nurses to doze in an easy chair over the paper or a magazine or novel and indulge in the flattering delusion that they are securing absolutely necessary repair of tissues when they are only yielding to laziness. Take your rest in bed, not dozing in a chair.

As to how much walking outside there should be, there are differences of opinion, but no one who has given any study to the subject thinks that there should be less than three miles of walking in the day and most are inclined to think that there ought to be four or five miles. This seems an almost impossible amount for a woman to walk in this modern time and yet it is very probable that nervous discomfort and irritability and over-weight would be prevented this way better than any other.

Getting air in and outside of the house is the most important prescription for health and equability and calmness of disposition and for lack of nervous irritability that can be given: You may feel that this is needless repetition but it cannot be repeated too often. The nurse should take every opportunity that may offer itself to walk out in the air. When her patient is asleep or not in special need of her she should be quite ready and willing and even offer to go on errands to the drug store or on other little excursions of that kind. She should also be ready to do some of the marketing for the family, especially if it is the mother in the house who is ill and the marketing should not be done over the telephone, that abomination of desolation for the modern woman's health. She should not mind, but on the contrary should welcome, the chance to take the children to school and bring them home at noon time and go for them at the end of school hours. There is no lack of dignity in this, and there is a fine opportunity for exercise in the open air that should not be missed. Exercise apart from outdoor air is not very advisable for the nurse. Gymnastics of various kinds are scarcely worth while, except for a few minutes immediately upon getting up in the morning, in order to set the blood circulating and drive the obsessions out of the brain and get rid of the little dreads that nervous people particularly hate to have to face in the morning.

Of course if there is a tendency to stoutness it may be necessary to go through certain exercises to keep fat from accumulating just below the waist line in front and over the haunches behind. The only means that will dissipate fat that has accumulated in these locations are bending exercises of various kinds, but it is an extremely difficult matter to get rid of fat in these regions and it is ever so much better to prevent its accumulation. Sedentary, that is, sitting habits, are the worst factor in this unfortunate deformity, for such it is.

Vigorous exercise in the open air is the best antifat that we have though of course even this will not serve the purpose in case delicacies of various kinds of fat producing materials are consumed in quantities. Air and exercise, however, are the two most important things for the preservation of health and for the maintenance of such a disposition of cheerfulness, helpfulness and readiness for emergencies as render a nurse invaluable, make her services appreciated, and cause her to be called on so often that her constant occupation is always assured.

Urological Departments in Modern Hospitals

Charles Pierre Mathé, M.D., Urologist to St. Mary's Hospital, San Francisco, Calif.

DURING the past decade urology has definitely separated itself from general medicine and surgery. The discovery and improvement of the cystoscope, the development of the various tests employed in the determination of kidney function, and the invention of numerous highly specialized instruments and operations are responsible for its present day status. Realizing this, the modern progressive hospitals of the world have, or are establishing urological departments. During the past few months it has been my privilege to visit the various hospitals abroad, making an intensive study of recent methods and advances.

In France, the Guyon Clinic at the Hôpital Necker represents one of Europe's best urological organizations. Under the direction of Professor Felix Legueu, medical students of the University of Paris and postgraduate students from all over the world are taught. About twenty-five years ago, Professor Hugh Young of Johns Hopkins University paid a prolonged visit to this notable clinic and obtained a clear conception of the fundamentals of urology as taught by Professor Guyon. He is largely responsible for the development of the present day high standard of urology in the United States. The clinic was founded and directed by Guyon, who was succeeded by Albarran in 1905 and by Legueu in 1912. One is amazed at the dexterity and finesse with which Professor Legueu operates. He has rightfully earned the reputation of being one of the world's most finished operators. In this hospital, lithrotripsy, or crushing of bladder stones, was developed and perfected by Civiale in 1829. At the present time, lithotripsies are skillfully made under local anesthesia. Numerous instruments for the diagnosis and treatment of urinary cases have also been devised. The discovery of a satisfactory process of making ureteral catheters from silk and gum has facilitated the collection of urine from the kidneys for investigation and study. In the cystoscopic clinic, "pyeloscopy" has replaced pyelography. This consists of a fluoroscopic examination of the outline of the renal pelvis. The pelvis is filled with thirty per cent sodium iodide and the outline is observed and copied on a semi-transparent chart which is placed over the film. Emptying of the pelvis is also observed. In this way improper drainage of urine from the kidneys is ascertained.

In Paris at the Hôpital Lariboisiere, Marion conducts a well organized urological department of one hundred beds. His ability, untiring energy, and genial personality have made numerous friends and admirers. I have counted no less than thirty visiting physicians from the four corners of the world in his surgical amphitheater. He has accepted Geraghty and Rowntree's phenolsulphonephthalein test and utilizes it in conjunction with the urea and chloride tests in determining the function of the separate kidneys. A few years ago, Marion devised a new, very satisfactory tube for the hypogastric drainage of the bladder after cystotomy. This consists of two unequal, united tubes. The tube with the larger diameter drains the urine away from the bladder, whereas, that with the smaller calibre is used in making vesical irrigations.

The Hôpital St. Joseph is conducted by the Sisters of Charity. One is impressed by the cheerfulness, willingness to serve, and the devotion of the good Sisters. Unaided by the government and sustained for the most part by charitable donations, they have established one of the cleanest, best organized hospitals in Paris. Much like St. Mary's Hospital in San Francisco, it is occupied both by pay and charity patients. Doctor Papin, a well known co-worker of Professor Legueu, is urologist-in-chief. He recently has worked out his "énervation des reins." This consists of incising the nerve filaments that accompany the renal artery. He does this to alleviate the pain caused by hydronephrosis of small size. His results are good. He also does a nephropexy on the same patient. I have had considerable experience in the efficacy of nephropexy in those cases of persistent, painful, mobile kidneys, unrelieved by abdominal belts. The question naturally arises, which relieves the symptoms—the enervation or the nephropexy? Bladder tuberculosis is treated by local injections of one per cent methylene blue, accompanied by its administration by mouth. Following its use, the capacity of the bladder is increased, the irritation lessened and the pain ameliorated. Tuberculous bladder ulcers are also treated by local application of trichloracetic acid.

The urological department of the Hôpital Cochin is conducted by Dr. M. Chevassu. A new building, to be devoted entirely to urology, is in course of construction and promises to be one of the most modern and complete in Europe. In the same hospital, Doctor Delbet has employed a preventive vaccine on four hundred gynecological operations. The vaccine consists of streptococci, staphylococci, and pyocyaneus. Three injections are given at two-day intervals prior to the operation. This apparently prevents the usual postoperative complications, such as phlebitis, infection of the wound, septicemia, etc. Doctor Chevassu is using the vaccine with equal success in operations on the urinary tract. In investigating a suspected tuberculous lesion, the opposite, healthy kidney is not catheterized. The transvesical urine is used in order to study the findings of the latter. The urea-secretory index, known as the constant of Ambard, experimental polyuria and determination of the concentration of urea in the blood, are used in studying renal function. All of these tests are repeated on two different days in order to make sure of the pathological findings.

In Austria, urology has made great progress under the guidance of Professor Zuckerkandl, Vienna.

Although he is deceased his numerous pupils are continuing his life work in separating urology from general medicine and surgery. At the Sophienspital, Professor Blum has a very good urological service. In making cystograms, radiograms are also taken in the sagittal plane. By this method, an injected opaque diverticulum, situated on the posterior bladder wall, can be seen. Indigo carmin is generally used in determining renal function. Three c.c. of solution containing 0.015 gm. of the dye, are injected intramuscularly and intravenously before the insertion of the ureteral catheter. Diminished function is ascertained by a delay in the appearance time, by diminution of the intensity of color and by a less active or frequent ureteral spurt. After this is determined, only the kidney with the weaker function is catheterized. Doctor Loenwenstein has recently demonstrated that avian tuberculosis, although pathogenic to man, is non-pathogenic to the guinea pig. This may account for our inability to diagnose certain early cases of renal tuberculosis. Doctor Loenwenstein successfully grows this type of tubercle bacillus on potato media after having subjected it to sulphuric acid. The firm of J. Leiter & Company has successfully made number 19 F. single and number 23 F. bilateral catheterizing cystoscopes and urethroscopes that can be sterilized by boiling. The entire instrument with its intricate system of lens and delicate incandescent globe, withstands a temperature of one hundred degrees centigrade. Doctor Glingar recently has devised a combination water and air cysto-urethroscope which can also be sterilized in the same manner. The same sheath can be used for either the water or for the air method simply by changing the observation piece.

At the Allgemeine Krankenhausen, a large establishment of four thousand beds, in Vienna, the urological department is a sub-department of the general surgical department. Professor Hochenegg is in charge. Under him are numerous doctors who make diagnoses of urinary diseases and give cystoscopic treatments. The urologic operations are made by members of the urological and the general surgical staff. This arrangement is not ideal. The entire department should be distinct and not under the control of any other. In this way greater progress will be made and thoroughness practised.

Germany has contributed much to urology. Professor Israel, whose numerous publications and books on renal surgery are well known, recently celebrated his seventy-fifth birthday. One is impressed by the similarity of the German and the Austrian schools. Both employ the same general type of cystoscopes, surgical technique, and the same dye, indigo carmin, in studying renal function.

At the Universitads Chirurgische Klinikum, Berlin, Professor Eugene Joseph conducts a well organized urological department. The surgical cases, however, are transferred to the general surgery department of the university. Professor Joseph also has a urological department in a private hospital, the Hygea Angsbürger. This is well organized for the diagnosis and treatment of urinary cases. His generous hospitality and untiring energy make a definite impression on visiting American urologists. He is the first to use chemotherapy in the treatment of inoperable malignant tumors of the bladder. This consists of the application of strong trichloracetic acid on the tumor. This reagent coagulates the tumor, reducing it in size, thereby ameliorating the symptoms. If the tumor is operable, he advises cystectomy or entire removal of the bladder. Professor Joseph has also introduced umbrenol for pyelography. It consists of a twenty-five per cent solution of jodlithium. It is so opaque that a small amount, i. e., fifteen cubic centimeters, readily diffuses throughout, giving us a good outline of the pelvis. By this method, rarely, if ever, is any pain experienced since it is not necessary to dilate the kidney pelvis in order to obtain a pyelogram.

Dr. Erwin Christeller is director of the institute of pathological anatomy at the Rudolph Virchowspital, Berlin. He has given us his ingenious method of making complete sagittal sections of entire pathological organs. This gives one a macroscopic as well as a microscopic picture of the whole specimen. It greatly facilitates the search for areas of malignant degeneration in tumors and for the discovery of small foci of tuberculous infiltration in a suspected organ. The pathological museum commenced by Virchow contains numerous interesting specimens.

The formation of the International Urological Society, shortly after the termination of the World War, has done much to bring urologists of various nations into closer contact. A great step toward progress is the foundation last year, in Italy, of a national journal of urology. We, in America, have always looked up to the European countries which have produced so many great men who have handed down to posterity their fundamental discoveries in medicine. I have observed that, in turn, all abroad are agreed that America is well advanced in hospital progress, surgical technique, separation of the various specialties, and in medical research. At the present day, the European urologist welcomes us with a broad open mind, not only to teach us his methods but with a desire to exchange ideas. He agrees with us in America that urology is a distinct specialty, separate from general medicine and surgery. Its present state of efficiency requires the employment of many highly specialized instruments for diagnosis and treatment, the use of numerous tests for kidney function, and an intelligent interpretation of the findings in a given case. It is universally recognized that in order to have thoroughness and efficiency in the diagnosis and treatment of urological cases, the modern hospital of progress must establish and equip separate urological departments.

X-Ray Technique

Tenth of a Series of Illustrated Articles by James F. Kelly, M.D., Assistant Professor of Radiology and Physiotherapy, Creighton University, Omaha, Nebr.

TAKING x-ray films of the teeth is probably the most difficult technique the beginner is forced to master. I say "forced to" because every day there are teeth to be x-rayed and the technician is compelled, very early in her career, to x-ray teeth whether she likes it or not and generally she does not. Due to the various angles to be considered and correctly judged, no examination results in such grotesque failure if not properly carried out as does the examination of teeth.

Due to the normal variation in individual mouths there are no laws to be laid down which will enable one to take perfect dental films from the start but there are a few things which may be mentioned as helpful and if followed, they should shorten the period of despair for the technician and disgust for the roentgenologist.

About the first thing to learn is the total number of teeth, the names of the different areas into which these are divided, and finally what teeth are found in each area. The usual complete dental examination is composed of ten films, each film for a different area. The names of the ten areas and the teeth included in each area are as follows:

1. The upper incisor area includes all the upper incisors, four in number, two centrals, a right and a left, and two laterals, a right and a left.

2. The upper right bicuspid area includes the upper right cuspid and upper right first (mesial) and second (distal) bicuspids.

3. The upper right molar area includes all the upper right molars, called the first (mesial), second (middle), and the third (distal).

4. The upper left bicuspid area includes the upper left cuspid and the upper left first and second bicuspids.

5. The upper left molar area includes all the upper left molars first, second, and third.

6. The lower incisor area includes all the lower incisors, four in number, two centrals, a right and a left, and two laterals, a right and a left.

7. The lower right bicuspid area includes the lower right cuspid and the lower right first and second bicuspids.

8. The lower right molar area includes all the lower right molars, first, second, and third.

9. The lower left bicuspid area includes the lower left cuspid and the lower left first and second bicuspids.

10. The lower left molar area includes all the lower left molars, first, second, and third.

The bicuspids and molars are named from before backwards, first and second, for the bicuspids and first, second, and third for the molars. The third molars are also known as the wisdom teeth.

The usual routine is to start as indicated above with the upper incisor area, as the film for this area is the easiest one for the patient to hold firmly in place. Patients who are prone to choke or gag lose all patience with the examination before a single film is obtained if the examination is started in one of the molar areas. On the other hand it is very easy to get the cooperation of the patient in the incisor area and they are very easy to handle if one works backward to the molar area which is generally difficult to radiograph. The patient should be told to hold the mouth open widely and to breathe through the mouth. If his attention is directed toward his breathing, the nervous patient will have less energy to use in choking and gagging.

The film for each area should show all the teeth included in that area. Of course, where just certain teeth are required and a full set is not to be taken, no attention is paid to area boundaries, the film being placed to get the tooth specified on the requisition. Therefore, when taking a full set of teeth, take according to areas but when taking individual teeth, the films should be placed to the best possible advantage regardless of area boundaries. There are, of course, other exceptions such as a narrow arch which requires an extra film for the upper cuspids. Extra films may also be required to get crooked overlapping teeth in other areas or to pick up a

FIG. 71.
UPPER CENTRAL INCISOR AREA.

FIG. 72.
UPPER RIGHT BISCUSPID AREA.

FIG. 73.
UPPER RIGHT MOLAR AREA.

tooth not satisfactorily included in the regular film for the area, etc.

The following technique is the usual hospital technique with the patient lying face up on the horizontal table. For the sake of clearness, each essential step in the procedure will be numbered or lettered, given in detail, and then repeated. Numbers refer to essential steps on upper teeth and letters refer to essential steps on lower teeth.

1 & A. Patient lying on table, face up.

2. For the upper teeth, place angle board under head with apex of the board toward the feet (Fig. 71). This makes it easy to rest the chin on the chest. N. B.

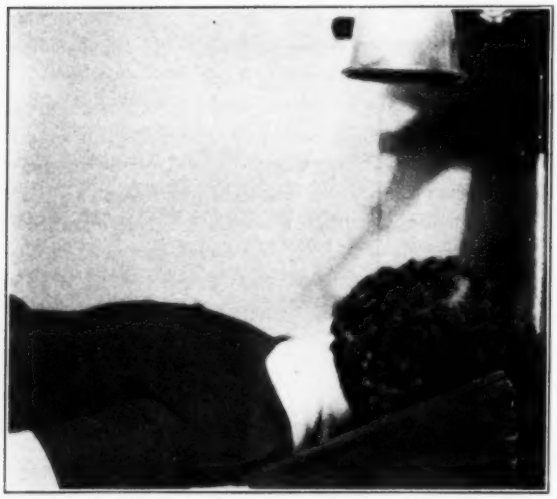


FIG. 74. UPPER LEFT BICUSPID AREA.

For individuals with short necks, it is sometimes necessary to place a sandbag or some other object between the back of the head and the angle board in order to elevate the head sufficiently. The angle board being too low for this type of patient.

B. For lower teeth, place a sandbag under the back of the neck (Fig. 76). This makes it easy to raise the chin off the chest.

3. For taking the uppers, the tube is tilted downward so the focal stream is directed toward the feet (Fig. 71).

C. For taking the lowers, the tube is tilted upward so the focal stream is directed toward the head (Fig. 76).

4. The dental film for taking the upper incisor area is held in place by the thumb of either hand, the chin is flexed downward on the chest and the focal stream is directed downward from above through the tip of the nose (Fig. 71).

Upper right side: The films for the upper right bicuspid area (Fig. 72) and the upper right molar area (Fig. 73) are held in place by the thumb of the left hand with the head rotated slightly toward the left for the bicuspid area (Fig. 72) and fully to the left for the molar area (Fig. 73).

Upper left side: For the upper left bicuspid area (Fig. 74) and the upper left molar area (Fig. 75) the films are held in place by the thumb of the right hand and the head is rotated slightly toward the right for the bicuspid area (Fig. 74) and fully to the right for the molar area (Fig. 75).

D. The film for the lower incisor area is held in place by the index finger of either hand and the chin is extended straight upward from the chest and the focal stream is directed upward through the point of the chin (Fig. 76).

Lower right side: The films for the lower right bicuspid area (Fig. 77) and the lower right molar area (Fig. 78) are held in place by the index finger of the left hand with the head rotated slightly to the left for the bicuspid area (Fig. 77) and fully to the left for the molar area (Fig. 78).

Lower left side: The films for the lower left bicuspid area (Fig. 79) and the lower left molar area (Fig. 80) are held in place by the index finger of the right hand. The head is rotated slightly to the right for the bicuspid area (Fig. 79) and fully to the right for the molar area (Fig. 80).

Upon reading the above descriptions, it is easy to realize that practically everything is opposite so to speak. If taking the uppers, the tube is tilted downward and the chin is flexed downward on the chest. If taking the lowers, the tube is tilted upward and the chin is raised upward off the chest. If taking the right side, the films are held in place by the left hand and the head is rotated toward the left. If taking the left side, the films are held in place by the right hand and the head is rotated toward the right. It must be remembered that upper films are held in place by the thumb and the lower films are held in place by the index finger. N. B. A greater tilt of the tube is required in the incisor areas than is necessary in the bicuspid areas and a greater tilt is required in the bicuspid areas than in the molar areas.

In the upper molar area, by getting off some distance and tilting but very little, it is possible for one to avoid the malar process which causes a dense shadow over the apices of the molars if these teeth are taken at short range, i. e., short film target distance. In the lower molar areas, it is possible to slide the film in deeply along the roots and therefore but very little tilt upward is required. One must remember, in the upper incisor area to flex the chin considerably and to tilt the tube downward considerably; in the lower incisor area to extend the chin considerably and to tilt the tube upward considerably.

In the bicuspid areas, less flexion of the chin on the uppers and less extension of the chin on the lowers and less tilting of the tube are required than is necessary for the incisors, while in the molar area, there is practically no flexion or extension of the chin or tilting of the tube necessary. Therefore, as one works backward toward the molars the tube assumes a more horizontal position for both uppers and lowers.

TABULAR SUMMARY OF PROCEDURE IN FILMING THE TEETH

Column "A"—For Upper Teeth

1. Patient lying on table, face up (Fig. 71).

2. Place angle board under head with apex of angle board toward the feet (Fig. 71). This makes it easy to flex or rest the chin on the chest.

N. B. For thick chested individuals with short necks it is sometimes necessary to place a sand bag or some other object between the angle board and the back of the head in order to elevate the head to the proper height, the angle board alone being too low for this type of patients.

3. The tube carrier is run to the upper end of the table and the patient must be placed far enough toward the foot of the table to allow the proper angle or tilt of the tube, therefore, the technician is working at the extreme upper end of the table and tilting downward toward the foot of the table on all exposures for films of upper teeth.

4. The chin is flexed downward toward the chest after the film is placed in position and before the exposure is made.

5. The films for the upper areas are held in place by the thumb.

Individual Areas
Uppers

6. Area 1—The upper incisor area consists of the four upper incisors. The films for the incisor or central area are held in position by the thumb of either hand, the chin is flexed downward on the chest, the tube is tilted downward toward the feet, and the central ray is directed through the tip of the nose (Fig. 71).

7. Area 2—The upper right bicuspid area consists of the upper right cuspid and both bicuspids. The film for this area is held in place by the thumb of the left hand. The head is rotated slightly to the left, the chin is flexed slightly, and the tube is tilted slightly toward the feet (Fig. 72).

8. Area 3—The upper right molar area consists of three molars. The film for this area is held in place by the thumb of the left hand. The head is rotated fully to the left, there is practically no flexion of the chin and very little tilting of the tube. However, the film-target distance is increased and the spark gap should be increased slightly or considerably longer time allowed (Fig. 73).

9. Area 4—The upper left bicuspid area consists of the upper left cuspid and both bicuspids. The film for this area is held in position by the thumb of the right hand, the head is rotated slightly to the right, the chin is flexed slightly, and the tube is tilted downward toward the feet (Fig. 74).

10. Area 5—The upper left molar area consists of all three molars. The film for this area is held in place by the thumb of the right hand, the head is rotated fully to the right, there is practically no flexion of the chin and very little tilting of the tube. However, the film-target distance is increased and therefore the spark gap should be increased slightly or considerably longer time allowed or some other factor increased to get the proper photographic results (Fig. 75).

Column "B" For Lower Teeth

A. Patient lying on table, face up (Fig. 76).

B. Place a sand bag under the back of the neck (Fig. 76). This makes it easy to raise the chin off the chest so the central ray may be directed under the mandible sufficiently low to project the apices on to the films.

N. B. For thick chested individuals with short necks it is sometimes necessary to place a sand bag under the upper thoracic area so as to elevate the shoulders and thereby allow a more complete elevation of the chin off the chest.

C. The tube carrier is run down toward the foot of the table until the tube is over the chest, therefore, the technician is working with the tube near the middle of the table and tilting upward toward the head on all exposures for films of lower teeth.

D. The chin is extended upward, that is, elevated from the chest after the film is placed in position and before the exposure is made.

E. The films for the lower areas are held in place by the index finger.

Individual Areas
Lowers

F. Area 6—The lower incisor area consists of the four lower incisors. The film for this area is held in position by the index finger of either hand, the chin is raised or elevated from the chest, the tube is tilted considerably upward toward the head and the central ray is directed upward through the point of the chin (Fig. 76).

G. Area 7—The lower right bicuspid area consists of the lower right cuspid and both bicuspids. The film for this area is held in place by the index finger of the left hand, the head is rotated slightly to the left and the chin is raised slightly from the chest (Fig. 77).

H. Area 8—The lower right molar area consists of three molars. The film for this area is held in place by the index finger of the left hand. The head is rotated fully to the left and there is practically no elevation of the chin and but very little tilting of the tube. This absence of tilting, etc., is made possible because the film as a rule passes parallel and deeply enough to get the roots without any additional angulation (Fig. 78).

I. Area 9—The lower left bicuspid area consists of the lower left cuspid and both bicuspids. The film for this area is held in place by the index finger of the right hand, the head is rotated slightly to the right, and the chin is raised but slightly from the chest, and the tube is tilted slightly upward (Fig. 79).

J. Area 10—The lower left molar area consists of three molars. The film for this area is held in place by the index finger of the right hand, the head is rotated fully to the right and there is practically no elevation of the chin and but very little tilting of the tube. This absence of tilting is made possible by the location of the film inside of the mouth (Fig. 80).

General Considerations

As a matter of protection both for the patient and the technician the hands of the latter should always be washed before and after the examination. In cases where Vincent Angina, specific infections, etc., are suspected or known to exist a germicidal wash should be used. Even gloves may be used if necessary in certain cases.

The patient in holding the films should not allow the fingers to get in between the focal stream and the film or the shadow of the finger will be superimposed upon the shadow of the teeth and will ruin the radiograph. Prevent this by pulling the elbow back and down toward the table (Fig. 75). The free hand should always rest on the table at the side of the patient and not be on the chest or abdomen and the tube should not be placed parallel with the long axis of the body

FIG. 75. UPPER LEFT MOLAR AREA.

FIG. 76.
LOWER CENTRAL INCISOR AREA.

FIG. 77.
LOWER RIGHT BICUSPID AREA.

FIG. 78.
LOWER RIGHT MOLAR AREA.

when it is tilted to take the lower teeth as it may touch or be close enough to allow the current to jump to the patient striking him on the abdomen or free hand. The tube terminals should also be kept at some distance from the metallic parts of the tube carrier or table lest the current should jump to these structures and shock or frighten the patient.

In this work, as in other x-ray work, there are two main dangers, the first one, is the danger of too much exposure to the x-ray and the second one is the danger of being shocked by the high tension current from either one of the tube terminals, overhead wires, etc.

In regard to the first danger, i. e., too much exposure to the x-ray, this may be brought about by taking too many films of a single area or it is possible to occur following the taking of even a couple of films if the spark gap, that is the voltage or penetration, is insufficient. One must always be sure that he is using enough voltage or spark gap to secure penetration because by a short gap it is possible to do an immense amount of harm in a very short time even with but two or three exposures. Always use one-half millimeter of aluminum while the exposure is taking place. This filter may be removed if desired while centering, using the Coolidge light for assistance in locating the exact direction of the focal stream, etc., but after the ray is focused, the filter must be replaced before the exposure is made.

In regard to the second danger, i. e., shock from a high tension current, one will have no trouble from this source, if the patient is compelled to keep his free hand by his side and the tube terminals are kept at least six or seven inches from the patient's body or any of the parts of the tube carrier, table, etc., and the tube tilting device is firmly locked after the desired angle is obtained, otherwise the tube might tip over and injure the patient.

At this point it may be worth while to mention that the films should never be held in place by any of the regular technicians. If the patient has a paralysis, ankylosis, arthritis or tremor or for any other reason is unable to hold a film in place, one who is seldom exposed to the x-rays should be instructed how to hold the films for the patient. (Please have this person wash his hands before and after). Be extremely careful that the stranger holding the films does not get too close to the tube terminals while the exposure is being made. Explain to him that he must stay at some distance from the wires and the tube as the current may jump and strike him if he gets close to the tube or wires. The operator should be within full view of the tube, over-head wires, the patient and any one near the patient, at all times during the exposure. As a general rule, all strangers coming to the x-ray room with patients should be given a chair and told to sit down and stay down.

The timer or operating switch should be one of the type which requires constant pressure on the part of the operator to obtain an exposure. This type of switch is more quickly shut off in time of danger. In addition, there should be a circuit breaker on the machine and the foot switch should be in a protected place lest some one should accidently step on it.

FIG. 79.
LOWER LEFT BICUSPID AREA.

FIG. 80.
LOWER LEFT MOLAR AREA.

No one should ever be requested to hold films for the intra-oral examination of insane or vicious patients. A mechanical holder may be used or extra-oral films of the jaw may be taken.

A diagnostic x-ray view of a tooth must show that tooth in its entirety from the occlusal surface to apex with as little distortion as is possible to make it. (See Fig. 81.) Distortion

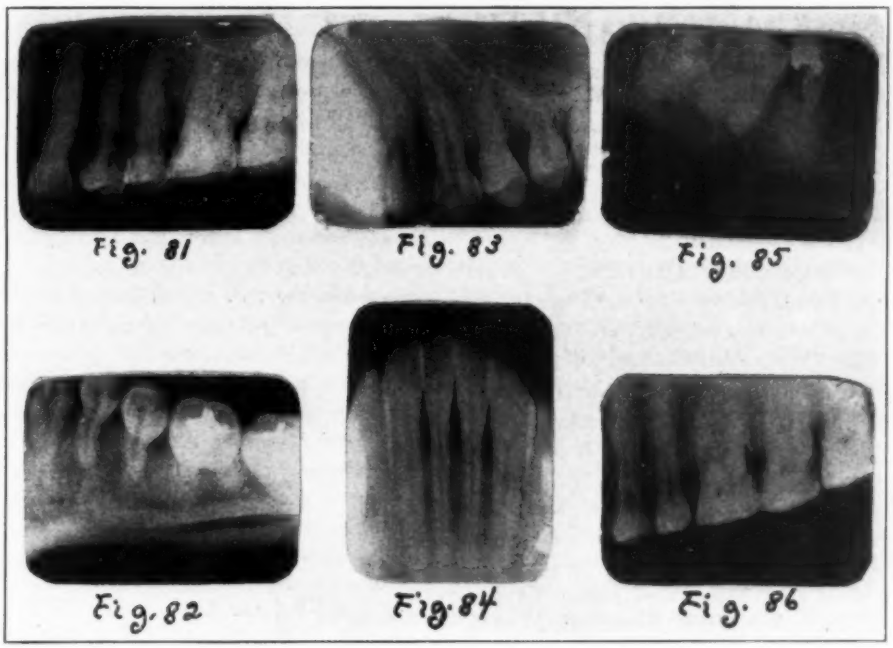


Fig. 81 shows an X-Ray film of the upper right bicuspid area. This area is the only one in the group which is taken correctly. The right cuspid and the first and second bicuspid are shown in their entirety and without any distortion.

Fig. 83 shows an X-Ray film of the upper right bicuspid area with the distortion caused by bending the film in the mouth.

Fig. 85 shows the lower left molar area showing the result of a film placed too deeply in the mouth, cutting off the occlusal surfaces.

Fig. 82 shows an X-Ray film of the lower right molar area. The teeth are shortened by too much tilting of the tube.

Fig. 84 shows an X-Ray film of the lower central incisors, elongated or lengthened by improper angling of the tube.

Fig. 86. This upper right molar area shows a film resulting from improper placement. The film was not deep enough to get the apices.

may be caused by incorrect position of head, improper angle or tilt of tube, or a poorly placed film in the mouth (Figs. 82-86).

In regard to placing the film in the mouth, let it be understood that the root ends of the dental films should never be bent or doubled back sharply in order to get the films so that the other end is on a level with the occlusal surface. To do this causes an elongation of the shadow of the roots and this distortion is fatal for diagnostic results (Figs. 83-84).

The film should be placed in the mouth behind the teeth which are desired, the occlusal end should protrude sufficiently to allow the entire body of the tooth and its occlusal surface to be demonstrated (Fig. 81). In Figure 85 the film is placed too deeply in the mouth cutting off the occlusal surface. Now, as stated above, the film should not be bent or doubled back sharply in order to secure this depth of insertion but may be gradually sloped back as in the uppers. If necessary the occlusal ends may be allowed to protrude for a considerable distance as is often necessary in the lower incisor area or may be necessary in any area as in Figure 81.

The essential thing under discussion here is that no sharp bends or curves are made by the surface of the dental film or destructive distortion will result (Fig. 83). A gradual sloping away from the roots of the tooth as is required by the roof of the mouth in the upper areas is permissible but this angulation is compensated for or neutralized by tilting the tube and flexing the chin on the chest, etc. It is true in all radiographic work, the greater the distance, the less the distortion and this should be remembered in doing dental work, however, the voltage and time must be adequate.

At close range, in the upper molar area, the malar process is projected onto the film over the roots of the molars and all other structures are considerably distorted.

The above article is by no means complete but there are some suggestions which will probably be helpful to the beginners in the technical work and that is the primary object of this series of articles.

Bazaar for Hospital. A bazaar for the benefit of St. Francis Hospital, Freeport, Ill., was held at the hospital during the week of Jan. 26. The affair was a genuine, old-fashioned bazaar with the familiar booths and various games and amusements including musical programs.

Improvements at Hospital. Many improvements at St. Anthony's Hospital, Terre Haute, Ind., during the last few months have been made possible, although not entirely donated, by Mrs. Walter Palmer in pursuance of the policy of her late husband Herman Halman, Jr., who always contributed generously to the hospital. Among the recent improvements were three sun porch wards for charity patients. They are quite large with new tile floors as well as radiators and electric lights. The kitchen also was improved by a new gas range, a separate gas oven, a new steam table to keep food warm, a new tile floor, and freshly painted walls and ceiling. The heating system was also improved much to the benefit of the Sisters and nurses. All these improvements, while expensive, are made for the future as well as the present.

Hospital Progress

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THE POWER OF TALK

Looking over HOSPITAL PROGRESS has it ever occurred to you how truly this is your own work, your own magazine, devoted to your interests, seeking to be helpful to your activities, desirous of effecting the highest ideals which must shape, guide and direct your hospital activities? In proportion as HOSPITAL PROGRESS becomes more excellent and effective, in that proportion, you will be helped toward realizing your better self, personal and institutional which beckons you on to greater and greater achievements.

Our better nature makes us as anxious to give as to receive. If you yourself are getting some profit whether in spiritual or scientific lines from HOSPITAL PROGRESS you will want to extend that benefit to others. Can you do so? You can, quite easily. You can at least talk about the magazine. What a power there is in talk! If you say to someone else in the hospital, "I read an article last night in HOSPITAL PROGRESS that you would be interested in," the one to whom you speak will want to know the title of that article, and will try to find time to read it. If you remark to one of the staff or one of the nurses, "HOSPITAL PROGRESS has an article this month which is just in your line," they will straightway become curious about the title and the author and will seek to get hold of the magazine and read it. If even one or two in the hospital make it a point every now and then to mention the magazine to others, it will not be long before almost everyone is interested in it. Many good things will follow from this interest—HOSPITAL PROGRESS will have more friends, more contributors, more correspondents who send in items and information, more well-wishers and more support and encouragement in every way. From this it will follow that the work of the magazine, of the Catholic Hospital Association, and of hospitals in general will be helped, improved, encouraged and increased. Such is the power of talk, of your personal, interested, persevering remarks and comments to the persons whom you meet concerning HOSPITAL PROGRESS.—E. F. G.

THE PSYCHOPATHIC PATIENTS IN OUR HOSPITALS

A recent lecture by Dr. Thomas Moore, of the Catholic University at Washington, on the subject, "The Biochemical Relation Between Mental and Physical Disorders," brings rather vividly to the writer the need of a better understanding in our hospitals of the situation surrounding those afflicted with the psychoses.

On every hand one meets with the thought that those regarded as insane should be relegated to public or private asylums. However, everybody recognizes that the stigma associated with such an incarceration is more or less permanent. The noted lecturer drew attention to the great field for a study of the various grades of psychic distress found among all populations. He left the impression that a little effort and care could easily provide for our larger institutions a definite clinic —out-patient or otherwise—which could easily handle many of the troublesome problems arising in mental disorders, and often restore the individuals to useful positions in society.

As to the part played by the hospital itself, it is usually considered that these patients are too noisy or too difficult to manage, for it to be proper to attempt their care in the same building provided for medical and surgical treatment. This feature deserves considerable study, because under proper supervision and with nurses and staff men trained to meet the exigencies arising in the treatment of mental disease, it is more than likely that this is a field which our hospitals could easily develop and find profitable.—E. L. T.

THE VALUE OF A SOCIAL WORKER

The sooner any hospital of any considerable size and importance secures a salaried social worker or several, if the work of the hospital requires it, the better it will be for everyone concerned. It is only because of the lack of understanding about the value of such a worker that some hospitals defer the introduction of this service. On the other hand, Catholic young people who are looking about for a career of usefulness should have their attention directed to the opportunities and consolation of hospital social service.

From the standpoint of economy, there is no question that the hospital social service is of singular profit to the hospital itself as well as to the patients. Charity cases socalled, that is to say, cases which come to the hospital for gratuitous service, are sometimes genuine, sometimes fictitious. When genuine they are always to be investigated by a skilled worker to find out just what social assistance the patient and his or her family need. We have often pointed out the fact that the hospital is a Providential point of contact with those who are socially ill-adjusted and that not only the patients, but their families and friends can be wonderfully helped when once contact has been established with them through the hospital. But very often the hospital workers themselves are too busy with other things to do this social work.

Hence the need of special workers. But, besides, from the standpoint of the hospital these workers can effect a very great saving by investigating the cases which seek free treatment and finding out those which are merely pretending to be in need of help. Some persons who can well afford to pay, victimize the hospital by simulating poverty and the social worker can detect this imposition. Finally, and this is of great importance, the trained social worker is in touch with all the sources of help for the poor and under-advantaged. Instead of calling on the hospital, which can sometimes

ill-afford to bear the burden, to support and help the needy families of patients and to give them supplies, etc., the salaried social worker can obtain these supplies from the great social agencies which are established specially for this purpose. Why should the hospital be called on to meet these expenses, when they can just as well be obtained from organized charitable agencies, and the hospital's resources thus conserved?

In the course of a single year, the hospital social workers can often save far more than their salaries in this way alone. Add to this that the very presence of a salaried social worker in the hospital is a sign that the hospital is progressive and takes a real interest in the welfare of its poorer patients especially. Such a worker, when well trained and prudent, can do a world of good in the name of the hospital and besides, can make many valuable sugestions about the social activities of the hospital.

In the clinics especially, and in developing the outside patients' department, who cannot see how important it is to have a well-organized social service department? We trust that it will not be long before every member of the Catholic Hospital Association will have taken active steps to that end.—E. F. G.

HOSPITAL INTERNS

"The actual practice of medicine is a craft and like any other craft must be transmitted from man to man. It does not solicit; it demands an apprenticeship that never ends. It has suffered and gained from its association with the learned, in an academic sense, but it will not much longer tolerate the barren futility of the present undergraduate course." This is quoted from the American Medical Association Bulletin for December, 1925, and is from the pen of Dr. John E. Jennings, Brooklyn, N. Y.

The same pamphlet has a very illuminating article from Dr. Charles P. Emerson, of Indianapolis, Ind. The following is quoted simply to whet your interest and urge you to read the rest of his remarks:

"I often have wondered if the Sydenhams, the Wier Mitchells, and the William Oslers of today are entering our medical schools. If one were to ask our preclinical men this question he might possibly receive the astonishing reply that medicine really does not need such men."

It is not that he finds such definite fault with the intensive teaching of "preclinical sciences," but he draws attention to the faulty premise that present-day medicine rests entirely upon them—"These sciences are the tools which the internist must use; but Internal Medicine is not implicated in the tools."

Interns are probably better trained today than ever before; as they leave our Class A schools, they have been so intensively "forced" and filled up with ways and means to assemble objective data that no wonder friendly critics find their analytical powers correspondingly less developed.

These interns enter our hospitals with a great need of acquiring perspective; as yet their knowledge is not well catalogued and indexed. This temporarily confusing period does not permit them to do their best. They have neither found their souls nor do they understand their personalities. To state simply that they are too technical implies forgetfulness of the fact that a mastering of technique precedes easy execution.

It is difficult to read Pupin's autobiography and still think that the quest of pure science is futile. Could anyone ask that great electrical wizard to have been a keener student of abstruse mathematics, or could anyone expect him more practically to apply its sublime principles? Let those who converse easily across our continent or "listen in" almost any night one-third the distance around the world give the answer.

Nevertheless, it is regrettable that much preclinical effort seems neither to impress on our students the "beautiful poetry of science" that guided Pupin, nor does it seem to supply the practical guidance the lack of which annoys Jennings and discourages Emerson. Accepting the known situation, is it not certain that our hospitals have a great duty to help their student interns to self orientation? These recent graduates come from the best laboratories in our country. Let us not too eagerly separate them from the moorings (lightly acquired) in the physical and chemical biological laboratories. Rather let us desire gradually to engraft some of their more fundamental ideas into our all-too-common routine, in order that ultimately the tree of human knowledge may expand. Most of all, let us assist these young graduates to find their own souls.—E. L. T.

FACTS

Facts are disagreeable things to face. Sometimes they are very hard to find, and when found we often like to avoid them.

Sometimes I wonder if communities such as Sisterhoods do not seem to find their avoidance easier than does the individual. It is so easy to pass the "buck." Our civilization and our educational system seem bent on escaping difficulties and it would seem we spend more time in removing difficulties and ignoring facts than we do in facing facts. Someone has said that, "If Demosthenes had lived in the Twentieth Century, instead of declaiming to the sea with his mouth filled with pebbles, he would have been sent to a specialist and had his adenoids removed and would have come out a perfect—mediocrity."

In hospital administration facts, even disagreeable ones, are constantly presenting themselves. They are often simple but always multitudinous. Do we always meet them as we should?

Father Moulinier has often said, aptly as well as alliteratively, "There are five duties we owe to facts: we must find the facts, focus the facts, filter the facts, face the facts, and follow the facts."

May I present this statement without comment for an hour's meditation by the Sisters in charge of each of our hospitals?—E. E.

Reducing Surgical Mortality[1]

A. A. Schultz, M.D.

SINCE this is the first meeting of the staff for the year 1926, I feel that it is advisable for us to reflect over the past year and consider what we can do during the year 1926 to improve the services rendered to the patients at Mercy Hospital. The surgical mortality for the year 1925 is not excessively high and is much less than in previous years, but I feel that it is possible to further reduce this mortality and I propose to discuss some of the methods by which we can lower our general surgical mortality.

In looking over the mortality from various types of operations I find that the death rate in 1925 has been far too high in cholecystectomies. I wish to talk chiefly about those patients who come into the hospital handicapped and not in good condition for operative work. These patients may be grouped as follows: 1. Diabetes. 2. Gastric retention cases. 3. Urinary retention cases. 4. Exophthalmic goitre. 5. Obstructive jaundice. 6. Obesity. 7. Secondary anemia.

It is a fact that five years ago the mortality from operations on these various types of patients was very high but it has been possible in the last two years in various institutions to reduce this mortality markedly by proper preoperative examination and treatment.

The diabetic should be hospitalized, the urine examined for sugar, acetone and diacetic acid, a glucose tolerance test done and the blood sugar estimation made frequently enough to determine the result of the dietetic treatment. These patients should be put on an accurately weighed diet restricting fats and carbohydrates and if necessary to increase the carbohydrate in the undernourished patient Insulin should be a part of the preoperative management. It is not enough to write an order restricting carbohydrates and fats but the order should be written in terms of grammes of protein, carbohydrates, and fat. When the patient is sugar, acetone, and diacetic acid free then it is time to operate. This sort of management has reduced in some of the larger institutions the immediate mortality in diabetes from ten per cent to two per cent.

In cases of gastric retention it should be routine to wash out the stomach two or three times a day if necessary until the washes are free from food particles and in the meantime the body fluids can be maintained by proctoclysis of normal saline or glucose. Two or three days in the hospital under this treatment before operation will certainly reduce mortality.

In those cases of cancer of the pylorus which are operable a preliminary gastroenterostomy is advisable and the resection can be made ten or fourteen days later.

In urinary retention due to prostate trouble the proper preoperative treatment is the thing which results in live patient following prostatectomies. In these cases blood chemistry is all important. When the urea nitrogen is from 40-60 mgms. per 100 c.c. operation should certainly be avoided because uremia is almost sure to develop. Even when the blood urea is over 30 the prognosis is bad and it is best if possible to keep these patients under observation until the urea nitrogen has gone down to at least 20 mgms. per 100 c.c. It is also important in these cases to determine whether you are dealing with a urine which is pale and limpid and has a fixed specific gravity around 1003. These cases are always serious and develop uremia on the least pretense. A phthalein functional test should not be omitted, but I don't believe it is as valuable in the prostate case as the urea nitrogen because the phthalein test indicates only the filtering power of the kidney while the blood chemistry is indicative of the reserve power of the kidney.

Before operating on a case of exophthalmic goitre you should always be absolutely sure whether you are really dealing with Grave's disease or a hyperfunctioning adenomatous goitre because in Grave's disease Lugol's solution is a very valuable aid in preoperative management, since it reduces the metabolic rate and the various general symptoms. In all of these cases basal metabolism tests should be made frequently before operation. These patients should always be in the hospital for some time before operating. They are always nervous and it is wise for them to become accustomed to their surroundings and get into a cheerful mood before being sent to the operating room. Finally, it is very important to be on the lookout for a thyroid crisis and not attempt to operate during this time.

Obstructive jaundice patients should by all means receive thorough preoperative management because we all know of the serious danger of hemorrhage in these cases. It should be routine to give these cases 5 c.c. of 10% solution of calcium chloride intravenously for three days before operation. The body fluids should be increased and carbohydrates in the form of glucose given by rectum in large quantities. The above results if followed out will reduce the possibility of post operative hemorrhage markedly.

All of us no doubt consider the fat patients a poor surgical risk and on account of this fact it certainly is wise providing there is no emergency to put these people on treatment for at least ten days before operation. There are two big things which cause the mortality to be comparatively high in obesity—first, the mechanical difficulty of abdominal operation, and second, these patients are prone to develop embolism and infection. Therefore, they should be put to bed for a week or ten days and the diet sufficiently lowered in calories to permit a reduction of from 10-15 per cent of the body weight.

We see quite a large number of cases of secondary anemia coming into the hospital for operation and many of these patients when placed on the operating table are in no condition for major surgery. For example, the patient with submucous fibroids who has been bleeding off and on for months, the duodenal ulcer case, bleeding hemorrhoids, or tumors of the gastro-intestinal tract. If the anemia in these cases is at all severe a blood transfusion before the operation is absolutely essential and will save many lives.

In any operative case it is of course essential to take a very careful history, make a complete physical examination regardless of where the pathology is supposed to be, do a complete blood count and above all do a routine Wassermann. You are all aware of the fact that syphilis may simulate any disease and by the routine taking of Wassermanns we may be able to save some of our gastric crisis cases from a laparotomy. Preoperative cases certainly should not be given strong catharsis nor should they be starved. In every operative case abundant fluids should be given. Operations should be started on schedule time and no patient should be required to wait for from one to three hours for his work to be done. Operations in cases which are hopeless should never be done

[1]Resume of an address delivered before the staff of St. Joseph's Mercy Hospital, Fort Dodge, Iowa, January 4, 1926.

regardless of the fact that occasionally the relatives insist. These operations simply add to the surgical mortality. Exploratory laparotomy is indicated only when all modern methods have been used to make a diagnosis and have failed and when it is plain that surgery may give relief.

In conclusion, I want to say that we must make a concerted effort to get more post mortems. A properly performed post mortem is the most valuable aid we have in increasing our knowledge of diagnosis. In no other way can we so positively discover mistakes in diagnosis and equip ourselves for better diagnosis in the future. More post mortems can certainly be obtained if the doctors, Sisters, and nurses will cooperate in obtaining the consent of the relatives. By persistent effort I am certain that in the future we will be doing a large number of post mortems in this hospital.

Hospital Records[1]

Sister Mary Olivia, St. Francis Hospital, Waterloo, Ia.

Among the various factors involved in the betterment of hospital service to the patient, one fundamentally most important is Hospital Records. They are the best index to the ability of the nurse, to the professional capability of the attending physician and to the actual service rendered the patient. They stand as an irrefutable evidence, either to exalt or condemn those concerned in the management of the case. From this point of view they have a decided medico-legal value.

There has been so much already said on this subject, that I feel it useless to go into detail. There are, however, two essentials in the composition of a record, that I wish to bring to your attention, namely: Records should be: 1. *complete;* 2. *accurate.*

Complete. No data should be omitted that would contribute to the successful treatment of the patient, or to scientific study or research work in the future. Hence the record should cover the period before the patient's entrance to the hospital, the period during his stay, and after his discharge. Now the forms used to make up a case chart differ considerably, in the various hospitals. However much these forms may vary in detail, there are certain requirements which are common to all. Every record must have a case history. This includes: (1) The history of the patient's previous health and of his present condition, his occupation, environments, and exposure to disease. (2) Family history including as far as possible the health or cause of death of ancestors and other relatives. The family history may be a source of suggestion as to predisposition or susceptibility to certain diseases and it may supply facts in research work on heredity. This is followed by report of the physical examination, laboratory report, progress notes, order sheet, temperature chart, and nurse's notes. The physical examination forms a component part of the case record, thus accuracy is essential, inaccuracy, however, is not infrequently the practice. It should be a complete, detailed description of the physical findings by regions and systems. The much used terms "*negative* or *normal* findings" are indefinite and therefore not satisfactory. After the physical examination is completed a working diagnosis should be written down, since treatment must be advised and some conclusion must have been reached as to what disease the patient is suffering from. Omitting the provisional diagnosis when this part of the record is filled out, the record clerk will find it impossible to make a complete report of cases at the close of the month, in which the provisional and final diagnoses agree or disagree. Thus this report cannot be otherwise than misleading. Fortunately, the omission of the provisional diagnosis does not occur so frequently on surgical as it does on medical records, for the reason that most hospitals have adopted the rule that the preoperative diagnosis must appear on record before the operation. Medical cases not subject to this procedure unfortunately get by on this point.

The operative chart is a part of the case record frequently consulted. One of the record clerk's greatest difficulties is the frequency of incomplete operative records. Too much stress cannot be laid upon the importance of a complete and accurate report of every operation. Everyone in connection with case records realizes the frequency with which inadequate information must be given in response to the many inquiries where the welfare of a patient, the reputation of a doctor, or equitable settlement of a law suit may depend upon the answers. Only by strict enforcement of rules regarding immediate and complete filling out of operative reports, including signature of the surgeon, assistants, and anesthetist, anesthetic used, duration of operation, and conscientious description of operative procedures, gross findings, and condition of organs when explored, can the patient, doctor, and hospital be safeguarded. The Sister supervisor of the operating room enforces the rules governing the completeness of our surgical records, namely: (1) The general history and physical examination with working diagnosis and routine laboratory report, accompanies each patient to the operating room. (2) Operative findings, technique, and organs explored are recorded immediately after the operation. (3) No surgeon who refuses to comply with this rule is permitted to operate.

Accuracy in writing progress notes which also forms an important part of the case record, should be given particular attention. This is a task most busy doctors and interns will shirk if they can. The more complete progress notes can be made, the greater the value of the record for consultation and study. All cases (unless the case be a very brief one) should have progress notes. Cases of a serious nature require daily progress notes. They should be written when the patient is visited and not from memory on the day of the patient's discharge, or, as it sometimes happens, even after the patient's discharge. Important items for entry on the progress sheet are: Complaints of the patient, evidences of complications, results of examinations and consultations, removal of splints, packings, drains, or sutures, and the condition of the wound especially when infection occurs in clean cases. Finally the condition of the patient on discharge, should be specifically stated as to the relief of symptoms and complaints, for which patient entered the hospital for treatment.

To insure completeness and accuracy in hospital case records the *follow up system* is essential. Every hospital should follow up its discharged patients either by means of questionnaire blanks or by means of medical, social service workers. A hospital that does not investigate the future condition of its discharged patients is working in the dark, is not fulfilling its full duty to the patient, to itself, or to the medical world, and its recorded results may well be viewed with skepticism. Too

[1]Paper read at the fifth annual convention of the Iowa Catholic Hospital Association, held at Sioux City, Iowa, Oct. 14-15, 1925.

frequently it has been noted with regret that patients once discharged from the hospital recorded as cured, come back a month later to the same hospital, or perhaps to another hospital with the same ailments. It is obvious then, that the investigation of the future of this patient is the only true record of the result of the hospital work. We do not have a social service worker directly connected with our hospital but affiliate with social welfare and local charities of the city, on those cases that require investigation.

In cases of death the record department will emphasize the necessity of the practice of autopsies as a logical procedure if the truth would be recorded.

To recapitulate:

1. Records should be complete and accurate.
2. Operative chart—special attention should be given to gross pathological findings.
3. Progress notes—more consideration must be given their importance, and value which cannot be overestimated.
4. Follow-up system—is essential to insure completeness and accuracy in the case record.
5. The cooperation of hospital authorities and entire staff is necessary to maintain a well regulated record department.

Record clerks realize their work far from being perfect and will happily receive any suggestions along this line to develop more accurate case records.

Simple Case Records

Case records have an important bearing on hospital efficiency. The Sister Historian of St. Joseph's Mercy Hospital, Fort Dodge, Iowa, has given us a brief description of the new system of case records used in her hospital. When a patient enters the hospital, an individual index card is made out for him. This is an ordinary 5″x3″ card with space for name, address, name of doctor, date of entrance and discharge, case number, and section number.

The section number refers to the classification of diseases and treatments into fifty-four sections according to the Nomenclature Book published by the Physicians' Stationery Company, Detroit, Michigan, e.g., 1—Abscesses, 2—Amputations, 3—Accident cases, 4—Arthritis. Each section is subdivided, e.g., Sec. 31—Abdominal Conditions (a) Appendicitis, (b) Colitis, etc. A card 8″x5″ is made out each month for each subdivision or diagnosis. The illustration shows an Appendicitis card for January. One line is used for a brief record of a case. The summary column of this card contains a summary of all the appendicitis cases treated during the month.

From this record system one can tell at a glance how many kinds of cases were admitted during the month as well as the number of each kind. It clearly shows the mortality percentage of each kind of case as well as the total mortality in all cases during the month. It is quite apparent that the simplicity of this system greatly facilitates the compilation of an annual report.

The data of treatment and results arranged in tabular form attracts the attention of staff members, furnishing a clue to the kind of cases that need particular study and observation that results may be improved. Such interest secures better attendance at staff meetings. It is not claimed that this system of case records is perfect, but it has the advantages of being simple and usable and is presented by way of suggestion. Some of our readers can, no doubt, add valuable suggestions towards the development of an ideal system of case records.

APPENDICITIS — SECTION---31

DATE	DOCTOR'S NAME	PATIENT'S NAME	AGE	SEX	TREATMENT	RESULTS	DAYS	SUMMARY
Jan	Meyers	Smith, J.J.	33	M	Appendectomy	Cured	I0	APPENDICITIS
	Jones	Brown, A.	23	M	" "	Died	I5	TOTAL NO.-----25
								DEATHS-------I
								MORTALITY % -----?
								POST MORTEMS------?
								CONSULTATIONS---?
								COMPLICATIONS
								I-Brown-Embolism
								2-Smith-Peritonitis
								etc.

A

Name Mr. J.J. Smith — Case No. 13033

Address Street and City

Doctor ----------

Entrance Jan. 2, '26

Discharge " 5, '26

Section 31

B

Case record cards in use at St. Joseph's Mercy Hospital, Fort Dodge, Iowa. Insert "A" shows patient's individual, identification card (3" x 5"). The large card "B" (5" x 8") shows how all cases of Appendicitis treated during the month of January are listed and summarized on one card.

The New St. Peter's Hospital, Olympia, Washington

ST. Peter's Hospital, Olympia, Washington, was founded, after many requests from the residents, by the Sisters of Charity of Providence, whose motherhouse is in Montreal, Canada, and who have many hospitals and schools in the west. Ground for the frame building was broken in the spring of 1887, and the house was ready for occupancy Sept., 1887. From that time, the number of patients seeking admission has increased rapidly, until at the present time an average of two thousand are received annually. The old timers of Olympia still speak lovingly of the first four Sisters who came to render spiritual and bodily succor to the people. Two of the Sisters are still performing their appointed work, though not in Olympia, and the old people remember them well, whenever they happen to come to the old St. Peter's. Twelve Sisters are now supervising the work of caring for the increased number of patients and meeting the modern demands for a better equipped hospital, but we feel sure the old patients would all say that the patients now receive no better care than was given them thirty-five years ago.

THE 1925 GRADUATING CLASS OF ST. PETER'S HOSPITAL, OLYMPIA, WASH.

About five years ago, the increase in the number of patients and the constantly growing work of the surgery and x-ray, as well as the number of applicants seeking admission, caused the Sisters to consider the opening of a training school, and this was carried into effect October 1, 1919, some of the space on the top floor being furnished and remodeled into well-lighted living and sleeping quarters for those desiring to start their profession at St. Peter's. A lecture hall was furnished on the main floor, where the doctors, in turn, give courses of lectures, four nights of the week, throughout the year. These lectures are but a small part of the three years' course open to those who desire to enter the profession of nursing. Those in training receive instruction each day from a graduate nursing Sister who is a registered nurse in the State, and who has had, besides, many years' practical experience in the hospitals of the Sisters of Providence. Seventeen nurses have graduated from the training school since it was opened, and seventeen more are now looking forward to the time when they will receive their diplomas. The school is recognized by the State Board of Nursing as being an accredited school, and the graduates have the privilege of taking the examination for their registration in any of the States, and this examination the graduates from our school are obliged to take upon their graduation, the successful passing of which gives them the title of Registered Nurse. Augmenting the classwork and lectures, is the work on the different floors, the surgery department and the maternity department, where they receive practical experience under the supervision of the Sisters.

During the past several years, the hospital and the doctors have cooperated with the local Red Cross Home Bureau, with the result that many, especially children, needing medical attention have been treated at the hospital. Many a child, sickly and anemic, has greatly improved in health, by the removal of enlarged tonsils and adenoids at the clinics arranged by the Red Cross Bureau.

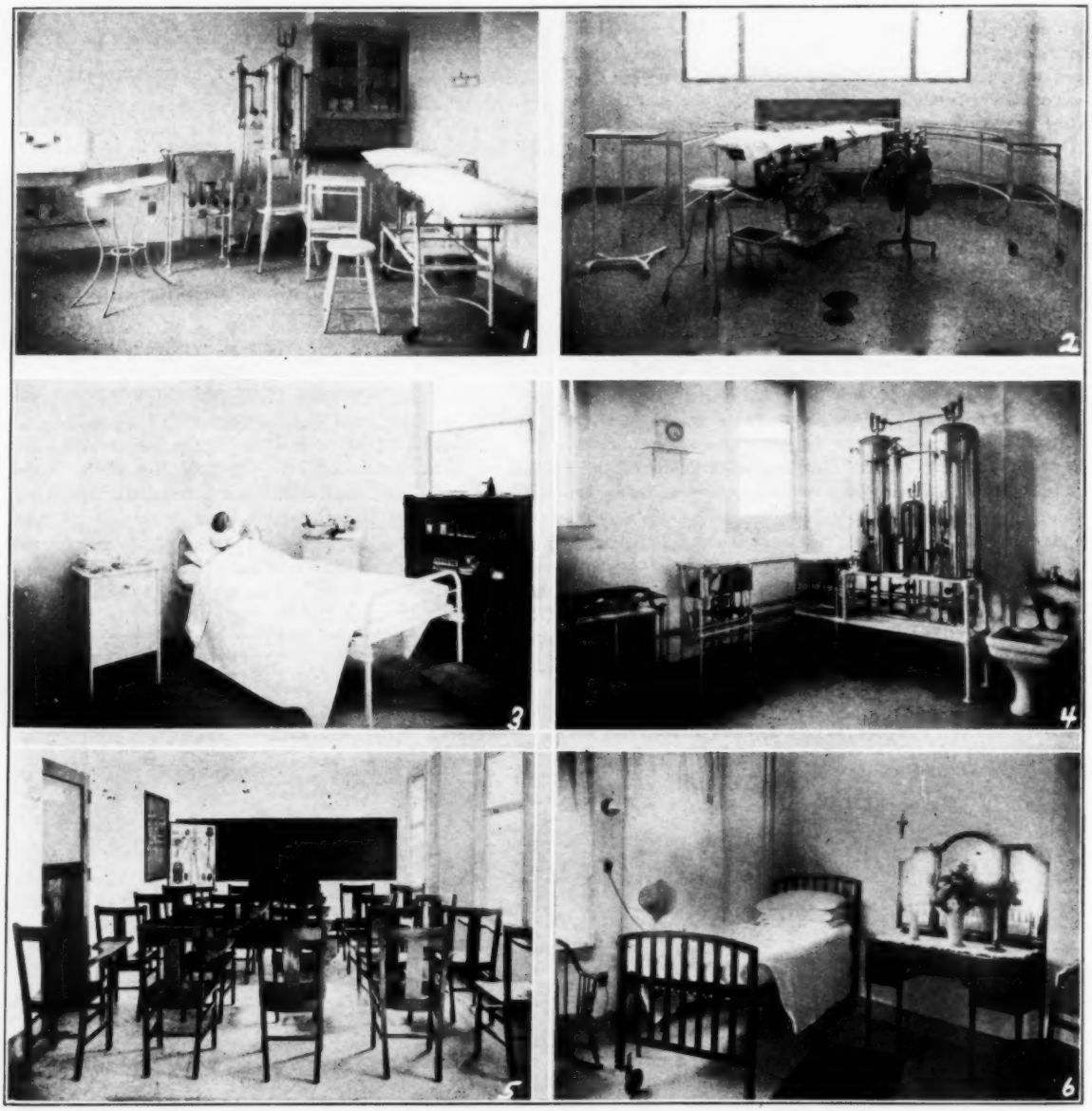
VIEW OF THE NEW ST. PETER'S HOSPITAL, OLYMPIA, WASH.

One young boy, suffering from malnutrition, gained about twenty-two pounds during a short stay at our hospital.

The pharmacy, from which the medicines for the house are supplied, is under the supervision of a Sister registered pharmacist, who fills the prescriptions and performs the other work connected with this department. The laboratory, which has had a small beginning, is slowly growing, equipment being added as needed. Each day finds the technician doing more and more work.

The new site, on the west side of Olympia, overlooks the Bay, and adds greatly to the beauty of the city. It stands on a mound, with a commanding view of the surrounding country and can, itself, be seen for several miles, from all parts of the city. With the Olympics on one side and Mount Rainier on the other, convalescing patients will be fortunate in having beautiful scenery.

The New Hospital, planned by Mr. John Graham of Seattle, was built by the A. W. Quist Company, also of Seattle, but who sublet contracts, when possible, to local dealers, in this way patronizing the Olympia people. The building, strictly fireproof, is five stories high, of reinforced concrete and brick, with terra cotta trimmings. In the basement are the boiler rooms, the laundry, and storage spaces, eleven rooms in all. On the first floor are the kitchen, the general offices, parlors, Sisters' and nurses' apartments, several small general dining rooms, in all totalling fifty-five rooms. The chapel, sleeping quarters for the Sisters and nurses, lecture and classrooms comprise the second floor, on which there are forty-three rooms. The third and fourth floors are for the patients, fifty-seven rooms on each floor, including private rooms and wards, and each room has its share of sunlight during the day, which is one of the



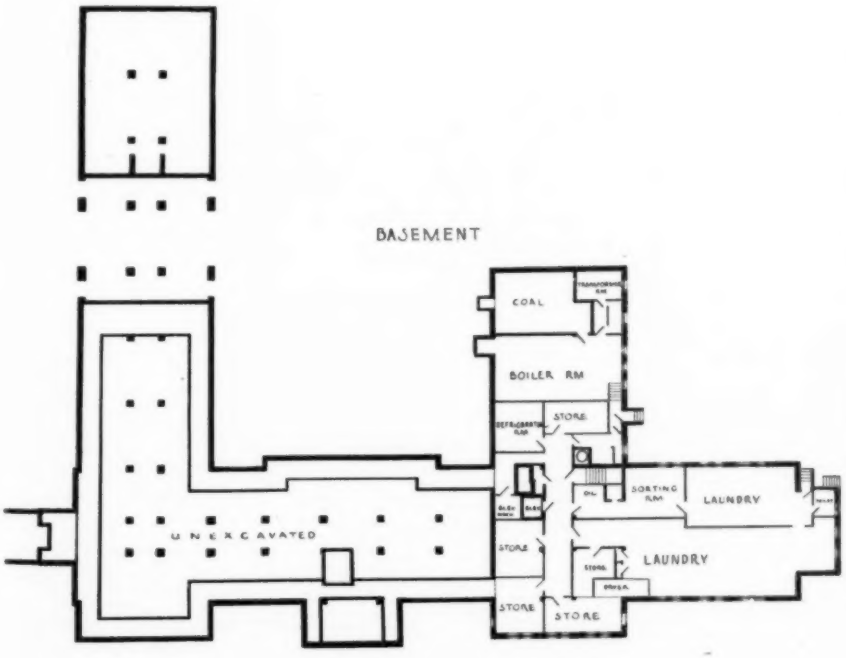
ST. PETER'S HOSPITAL, OLYMPIA, WASH.

1. Dressing Room on the Men's Floor. 2. One of the Major Surgeries. 3. Demonstration Room, Nurses' Training School. 4. Sterilizing Room on the Surgery Floor. 5. Nurses' Lecture Hall. 6. A Private Room on the Women's Floor.

THE CHAPEL AT ST. PETER'S HOSPITAL, OLYMPIA, WASH.

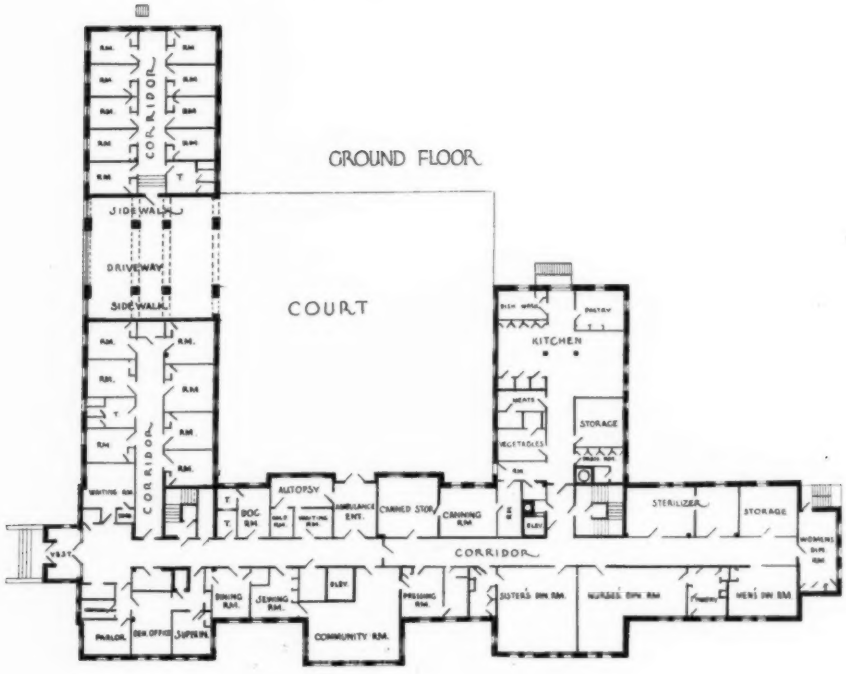
many advantages of the building as it is planned. Another special feature is the several solariums on each floor, where the convalescent patients can spend their time. The fifth story, containing twenty-six rooms, will be used for operating and x-ray rooms, laboratories, and specialists' quarters.

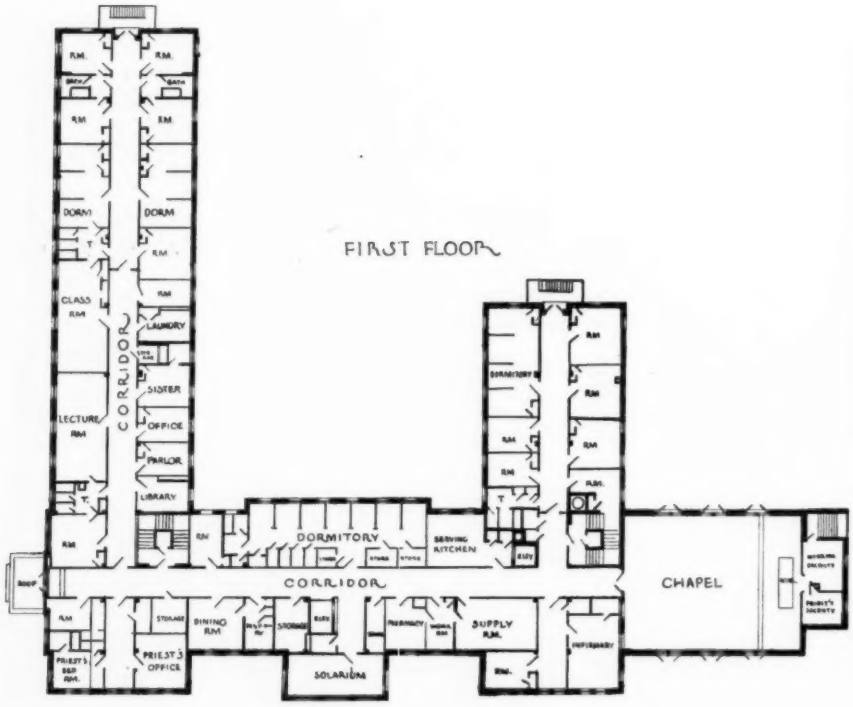
One feature of the new building is the facilities for accommodating the maternity patients. The hospital will be equipped with all the modern appliances and equipment, with two delivery rooms and a well lighted and pleasant nursery. The floors throughout the building are of terrazzo, and the building has special, modern appli-



ST. PETER'S
HOSPITAL,
OLYMPIA,
WASH.

John Graham,
Architect
and
Engineer,
Seattle,
Wash.





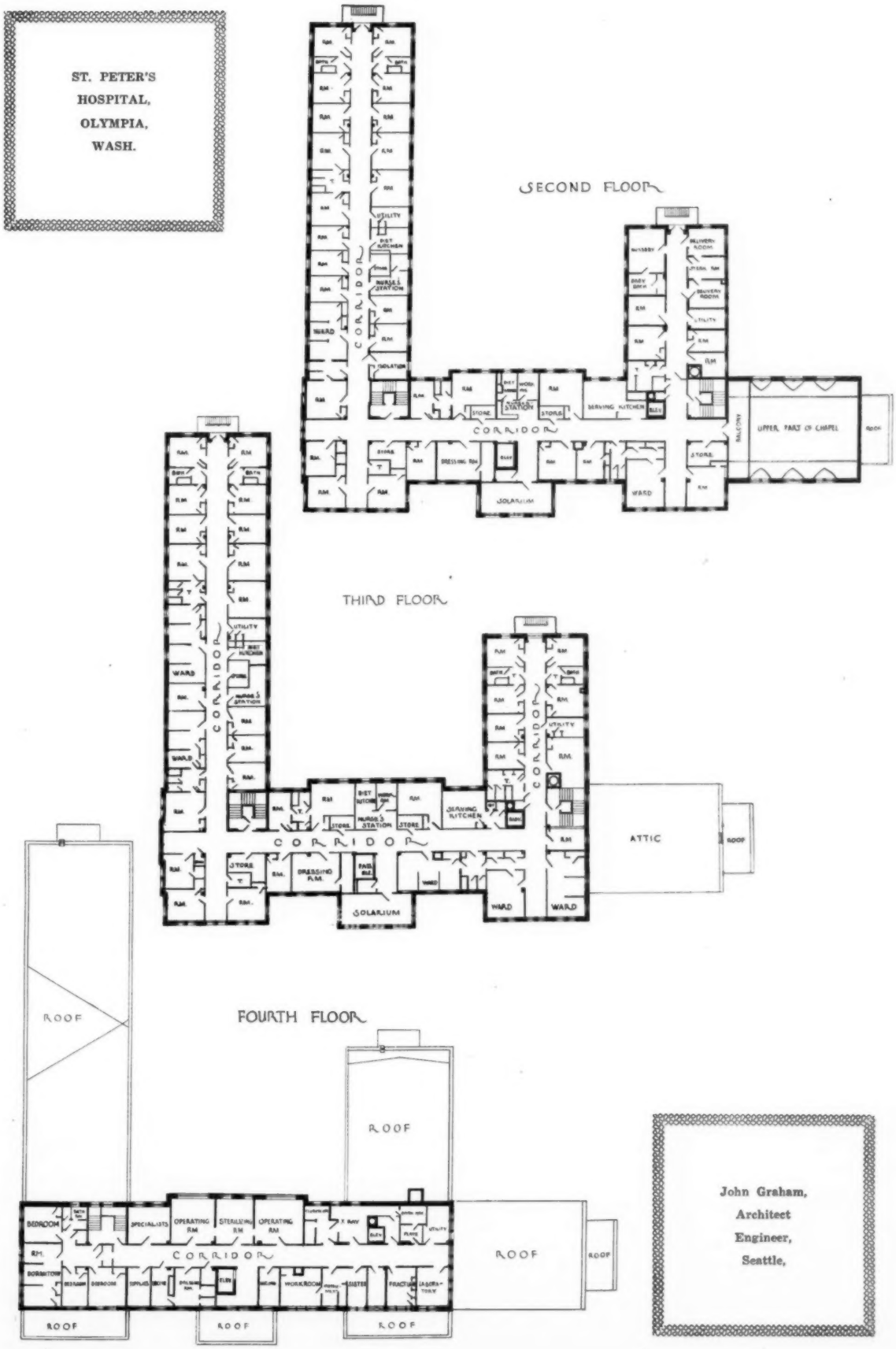
ST. PETER'S
HOSPITAL,
OLYMPIA,
WASH.

John Graham,
Architect
and
Engineer,
Seattle,
Wash.

ances for carrying away the waste and the soiled clothing to their proper depositing places.

We could hardly speak of our new hospital without saying a word of the chapel, which is located on the second floor, and overlooks the Bay. It is expected to furnish the chapel from the beginning with the best that can be secured for its size and location, so that those who visit the chapel, and the patients who are able to find consolation in visits and communings with their Silent Friend of the Tabernacle, will realize that the Sisters wish to show their appreciation of the thirty-seven years' blessings and protection, and their trust that the same Friend will bless and protect them for many years in the new St. Peter's Hospital.

ST. PETER'S
HOSPITAL,
OLYMPIA,
WASH.



John Graham,
Architect
Engineer,
Seattle,

President's Address at Missouri-Kansas Conference[1]

Sister M. Constance, St. Anthony's Hospital, St. Louis, Mo.

In his closing address at the first meeting of the Catholic Women's Union of Austria in April, 1910, the learned Cardinal Faulhaber spoke as follows of the advantages of organizing our social and charitable endeavors: "Organization is the most potent remedy in the social life of our time. Organization is, so to speak, the Eighth Sacrament in the 19th, and 20th Centuries."

The great churchman referred especially to the need of organizing those institutions and those bodies that are devoted to the service of the poor, and of the sick in hospitals.

Hence, I can hardly choose a better text for this address, which it is my privilege to make as president of the Missouri-Kansas Conference of the Catholic Hospital Association, than the words just quoted.

When we organized at the beginning of last September the press of St. Louis was very generous in the notice it took of our proceedings. The hope was voiced that the "amalgamation" of the hospitals of the two adjoining states would lead to greater progress and efficiency. We may now take a retrospect of the past year, and ask whether those hopes have been realized.

From the annual report which I will read, we can see that progress has been made. But progress can be achieved in various ways. Some persons are of the opinion that it is only big numbers that tell of progress, and they are impressed only by elaborate statistics. But there is a certain kind of progress which is very real, though it cannot be measured by numbers, nor proven by statistics.

This is, as far as we are concerned, a greater joy and satisfaction in our work, a realization that we are now serving the community better than we have done years ago, and a feeling that the community is looking upon us and our work as a great asset to them. Now in all of these ways has progress been realized. For we all take keener interest in our work, the fact that we must now measure up to certain standards has increased in us the love for our vocation and life of service, and we feel that the outside world regards us as important factors in the health and happiness of all.

But to return to the saying of Cardinal Faulhaber. He speaks of organization, that is of amalgamation, as one of the potent factors for good in the social life of today. I think that those who represent the many hospitals now in this Association, realize the truth of these words. Time was when we were struggling along as little and obscure units, caring little of what was going on in other hospitals not under our particular community, and perhaps even afraid to meet representatives of other institutions.

All this has now been changed for the better. We are glad to exchange our experiences and to learn from one another's methods, and even to admit if necessary, our shortcomings. And the result has been a genuine improvement all along the line, and as I have said, a new spirit of joy, of zeal, of fervor in our blessed work.

We also realize that we can all gain from our common experiences, and that we can improve our plans and methods by frank discussion.

The day of insularity has passed and the day of solidarity has dawned. And the amalgamation we accomplished last year, will pave the way for great and beneficial results. These results will be not only in the improvement of our individual institutions, but will also be shown in greater zeal in our religious vocation.

And let us hope too that another good effect of this new spirit of energy and efficiency will be the gaining of recruits for the high and holy cause that unites us—that is, of young willing hearts, ready to dedicate themselves to the service in which we are engaged.

However, it is well to recall on this occasion that we now have not only the material advantages resulting from union and cooperation in a common work. We have besides this the spiritual bond of charity uniting us in the same holy work. We have also the inspiration of the good example of workers in the thirty-nine institutions, at present members of the Conference. Moreover, the Sisters and nurses engaged in other hospitals will be an incentive to each one of us to labor unselfishly in the holy cause to which we have dedicated our lives.

Cardinal Faulhaber refers to the blessed woman Veronica, who offered the handkerchief to our Lord on His way to Calvary, as a model of those who devote themselves to the care of the sick and wounded and convalescent. We have reason to be proud of this holy model. But in order to be worthy of her, and in order to be her faithful followers, we must always work and serve with the spirit of charity in our hearts, and from a supernatural motive. It has been shown time and again that this supernatural motive in our work and duty does not make us less efficient, but rather more efficient. Hence let us never forget our dignity as religious Sisters, and nurses, and servants of the sick.

One of the brightest pages in the history of our Church is that which tells of the work of the religious communities in the past for the suffering and infirm of Christ's flock. Let us imitate those apostles of charity, many of whom are now inscribed on the calendar of the saints as the true heroes of our race.

If we go forward in this spirit of zeal and charity, the coming year will bring new strength, as well as new opportunities for service, to the hospitals of these two adjoining states. We have a glorious past as religious workers in the cause of suffering humanity. It will be our duty during the coming year to live up to our fine tradition, to gain new honor for the name of Christ Whom we serve, and to work ever more zealously for those who are in pain and distress.

A questionnaire was sent out in May to each Sisters' hospital for a report of the work done in the hospitals of our Conference during the last year. The questions asked were:

Questionnaire for the President's Report, Missouri-Kansas Conference of the Catholic Hospital Association, September 1-2-3, 1925

1. Have you erected new buildings or additions?
   For what purpose—as convents or hospitals?.....
   Does this give you increased bed capacity?.....
   How many?.....
2. How many patients were received last year?
3. How many patients were treated in the out-patient department?
4. How many Registered Sister nurses in your hospital?
5. How many trained Sister technicians have you?
6. How many Sisters in training?
7. Have you a Sodality for lay nurses?
8. Have you been able to do anything to spread interest in the International Nurses' Guild? If so, what?

These questions were answered by every hospital, with the exception of one in Missouri and one in Kansas, with the following results:

[1] Delivered at Missouri-Kansas Conference of the Catholic Hospital Association, held at Kansas City, Mo., Sept. 1-3, 1925.

One new building, a Novitiate.

Addition to hospitals, 4, including one Pediatric department.

One Out-Patient department.

One cottage for hired help.

Bed capacity increased 520.

Patients received last year, 53,040.

Patients treated in the Out-Patient department, 43,191.

Registered Sister nurses, 301.

Trained Sister technicians, 77.

Sisters in training, 83.

Sodality for lay nurses, eleven hospitals have.

The last question, regarding the interest spread in the International Nurses' Guild, was mostly negative.

The Influence of the Hospital Sister on the Lay Nurse[1]

Sister Mary de Lellis, St. John's Hospital, St. Louis, Mo.

THE influence of the hospital Sister on the lay nurse, based on supernatural motives, promotes a mutual understanding, an efficient, enthusiastic service, and higher standards of professional ethics. This influence will animate the lay nurse to a generous, impartial, service to suffering humanity. It will prevent her from relaxing when weariness or fatigue may tempt her to perform her duties less nobly or perfectly.

In order to render this influence profitable to the lay nurse the Sister must be at all times a source of helpfulness. It is necessary that she must be a competent nurse, a kind teacher, and a shining example of self-sacrificing devotion to duty.

The hospital Sister's influence must be founded on kindly consideration, a deep human insight into the needs of the lay nurse, a constant vigilance, fortified by the virtue of justice, the creation of the altruistic spirit, and her influence on the spiritual, intellectual, and physical life of the lay nurse.

This kindly consideration of the Sister must not degenerate into familiarity or partiality. It must be manifested by a personal cooperation, and animated by a love of service in fulfilling the precepts of her Divine Master and Model, by assisting in the care of His dear suffering ones.

The hospital Sister's deep human insight into the needs of the lay nurse is of paramount importance. It must be utilized with great tact, sympathy, and kindness; in order that her directions may be as easily and gratefully received, as they are kindly given. In this relation to the nurse the Sister must possess a reasonable knowledge of psychology, as well as fervor and zeal. This will enable her to exercise a great prudence and intellectual discernment, which will enlighten every relation in its action. She must also possess the ability of being accessible at all times, and of having a good foresight to provide for the arising contingencies, thus avoiding awkward situations and unnecessary friction.

A constant vigilance fortified by the virtue of justice must be one of the prevailing influences. This will insure that the patient's interests shall be the first, last, and uppermost consideration. In this justice there will be no partiality. Neither shall the hospital Sister be blind to the good done by the lay nurse, or miserly in expressing her appreciation. The Sister must know how to correct, when to overlook, how to be firm, and still retain a gracious, religious dignity.

The Sister must create the altruistic spirit in the lay nurse, by her example of tender charity to the poor and destitute. The nurse will be quick to perceive as well as to imitate her example and profit by her instructions. She will realize that whatever is done to the poor of Christ, He accepts as done to Himself personally. Although the lay nurse receives remuneration for her labors, she will also give her services to the poor and needy in the spirit of charity, based on supernatural motives. It is with this motive alone that the lay nurse will successfully fulfill the arduous and ennobling duties of her profession; and this will be the keynote of her fortitude and happiness.

The most important influence of the hospital Sister must be on the spiritual, intellectual, and physical life of the lay nurse. It is the most important side of the nurses' training, in order to make her truly efficient. The Sister must be zealous in nurturing a religious spirit in the nurse by her example and instructions. She shall see that the lay nurse makes use of the ample time arranged for her to fulfill her religious obligations. Neither the crowding of the courses of study or the pressure of more practical work must interfere with this great requisite.

The intellectual life of the nurse must be influenced by the habit of persevering study and good reading. This will demand sacrifice by the giving up of hours of pleasure or much needed rest for the acquiring of knowledge. The Sister must cultivate in the nurse a taste for good reading. In fact, she must consider this one of her chief duties; in order to lead the lay nurse to an avoidance of present day vulgarities, and even to a better love and practice of her faith.

The health and strength of the lay nurse is of vital importance, and can only be maintained by the proper environment and the observance of the laws of health. The physical life of the nurse will also be benefitted by the religious influences enumerated above, which will maintain right thinking and right living.

One of the most beneficial influences of the hospital Sister, the one which affects the nursing profession at large, is the early guidance of the prospective lay nurse, the probationer. It is often this young woman's first meeting with the hospital Sister; and her ideas are always vague regarding the nursing profession, its trials, responsibilities, and great rewards. In order that much benefit may be derived during this initial period, the Sister's spirit of loyalty to the interests of the sick will make a careful scrutiny in determining the adaptability of the candidate. In estimating this ability the Sister must not rely on superficial observation, or on the opinion of one or two. This can be determined only by discriminating observation. Hence, the Sister's great responsibility in retaining only the young woman with the requisite ability. The hospital Sister often perceives in fulfilling her sacred duties the different types of student nurses. their fine qualities, and their short-comings; some have faults yet possess the necessary traits of character to be moulded into good nurses. Neither space nor time permit me to discuss the effect of good influences on them. Suffice it to state, that no influence should be brought to bear that would dismiss them on trivial grounds.

[1]Paper read at the Missouri-Kansas Conference of the Catholic Hospital Association, held at Kansas City, Mo., Sept. 1-3, 1925.

Thus the influence of the hospital Sister, animated by the spirit of her holy vocation, will not alone promote the practice of the highest ideals of nursing in her hospital. It will also be indirectly instrumental in conveying to hundreds of nurses the true spirit of the nurses' calling, together with the proper technique, which will become part of the lay nurses' creed and conscience.

The paramount influence of the hospital Sister must be the cultivating in the pupil and graduate a sense of the importance of a supernatural outlook on the world, the necessity of prayer, generosity, and self-sacrifice. This will be a powerful means of assisting the lay nurse in fulfilling her sacred obligations; perhaps even in encouraging a religious vocation where one exists. Whether the nurse has a vocation or not, it is of supreme moment that she should understand the importance of time well spent, and of life's goods in the light of eternity.

The Service of the Hospital to the Small Community[1]

J. H. Kolb, College of Agriculture, Madison, Wis.

I. The Service Relations of the Town and Country Community.

THE hope of the farmer for maintaining an American standard of living depends not only upon his ability to show a net return from his production processes, but also upon his ability to win satisfaction for himself and his family in the whole realm of consumption. Many elements go into any standard of living. Every family has to consider not only the physical elements of food, clothing, and shelter, but also the community relations of education, recreation, and health. In fact, an authority on social work and standards of living, Dr. E. T. Devine of New York City, declares these latter elements are just as important as the former. In the long run, the farmer's ability to get what he wants for building his standard of living depends upon the kinds of service institutions which are accessible to him.

Conclusions gleaned from several studies definitely indicate that the farmer is dependent upon agencies and institutions which lie beyond his own farm gate. He has to go to the nearby village or town. If methods and principles which belong to the past are employed in these service centers, then he and his family are sooner or later the victims. Their efforts at reaching right standards of living are hampered. The hospital is one such service institution located in the town.

II. Some Findings from a Study of Three Service Institutions—Hospital, Library, and High School—in Eight[2] Small Town and Country Communities in Wisconsin.

1. State-wide observation: Thirty-eight and six-tenths per cent of the general hospitals have rural relations, for they are located in places of 5,000 or less population. Nine counties have over 1,000 people for every general hospital bed. Nine counties have one bed for every 250 people. Twenty counties have no general hospitals. Of the general hospitals, 35.1% have less than 25 beds. Small hospitals are usually found in small centers. Of the towns from 1,300 to 3,000, 20% have general hospitals.

It is evident from the picture just outlined of the general situation in the state that the problem of the rural hospital has a number of important angles which need to be considered. First, the distribution of rural hospitals over the state is far from uniform. It would appear that people in some of the counties have a fair opportunity of securing this service when needed. In many other counties this opportunity is entirely lacking. Second, the distribution according to the size of towns does not seem to follow any particular plan or logic, save a tendency for small hospital units to be found in the smaller centers. Some small towns have two or more of these small hospitals, and many have none. Third, the origin and service of the hospitals are often closely related to the doctor who is working on his own private initiative, and who is more or less influenced by the ethics of his profession. Fourth, the ownership policy and control in 83.3% of the cases is frankly private. Such private operation may be undertaken by a resident, a doctor, a nurse, a railroad company, a society or organization, or by a church or school.

2. There are wide variations in the hospital service of the eight town communities: But six of the towns have hospitals. Two towns have two hospitals each. The average number of beds is 15.5; range, 5 to 37. The average assessed valuation is $23,000; range, $9,500 to $50,000. The average number of cases is 215; range, 69 to 624. The average number of doctors using the hospitals is 2.7; range, 1 to 4. The average cost per bed is $402.44; range, $200 to $600. The average cost per case, $28.16; range, $14.49 to $40.00.

3. Community Character of Services: The service areas for these institutions differ greatly from those mapped out for the high school and library. The hospital areas are much more indefinite in extent; they extend over much wider territory, and they are not mutually exclusive. The area for one town may include whole or partial areas of neighboring towns. Nearly every small town community area lies within an area served by some large city hospital. One hospital reported having had cases from fifteen surrounding towns. Another reported having a fifty-mile radius for its area. The hospital service is a specialized service. The personality and the acquaintanceship of the surgeon count for much. It soon becomes generally known what type of cases he handles with the most success.

When the actual records of cases handled during the year are analyzed, an average of 215 cases per hospital, and 12.1 cases per available bed is found. The percentages for these classifications, surgical, medical, obstetrical and contagious, are 60.3, 30.8, 6.4, and 2.5 respectively.

When the analysis is made on the basis of residence of those receiving the services, on the average 31.0% were from the local town itself, 42.5% were from farm homes, and 26.5% were from other towns. When considered town by town, these percentages show the usual wide variation. The variation is still characteristic when two institutions within the same town are compared. For example, one of the Waupaca hospitals reported only 22.8% local town cases, and the other 66.7%. With the exception of Elkhorn and Medford, the per cent of cases

[1] Paper read at the Conference of the Wisconsin Hospital Association, held at Milwaukee, Nov. 17-19, 1925.

[2] Towns studied—Arcadia, Barron, Elkhorn, Fennimore, Medford, Mt. Horeb, Tomahawk, Waupaca. Year of study—1923.

from other towns is not large. It is these Elkhorn and Medford figures which have skewed the general average.

III. Unit Requirements in Terms of Community Organization

1. Suggestive unit requirements compared with U. S. Census averages and with the findings for the eight Wisconsin communities: If the community service of hospitals is to be improved, the necessity for more careful thought and planning in this field of rural life is immediate. There is no uniformity of plan or purpose. There are scarcely any regulations or standards imposed. The public or the community interest has often been neglected or disregarded. The idea of unit requirements in order to make possible an efficient service has little vogue. In seeking an introduction to possible ways and means, the officers, members, records, and literature of the American Hospital Association, the Catholic Hospital Association, the American Medical Association, and the Wisconsin Hospital Association were consulted. Their services are available to any local community in need of real help and advice regarding its hospitalization plans and problems. This section must be concluded by a mere statement of comparisons of unit requirements, gleaned from these sources, with general averages for the country as a whole set out by the U. S. Census Bureau, and with the conditions found in the eight Wisconsin towns.[3]

	Unit Requirements	U. S. Census Averages	The Eight Wisconsin Communities
Beds Per 1000 Population.	5	2.3	2.6
Beds per Hospital.....	50 (a minimum of 25-30)	71.0	15.5
Cases Per Bed Per Year..	25	18.7	13.4
Time Beds Occupied During Year.....	80%	62.6%	46.0%
Costs Per Capita Per Diem	$4.00	4.81	3.50 (operating cost only)

It should be evident from these comparisons that the very small hospital units are subject to difficulties in attempting to render efficient service to their communities. The leaders quite generally agree that these difficulties multiply when the capacity falls below 30 beds. The overhead charges are too heavy to carry. The volume of business is not sufficient to make possible first class service with modern equipment. If the suggestion for reasonable hospital service, namely five beds for each 1,000 people, is followed, a population unit of 5,000 to 6,000 people would be required for the minimum twenty-five or thirty bed hospital. Two of the eight town communities do have more than this number of people, but one of these towns has two hospitals and, therefore, does not meet the requirements. It is small wonder, then, that the beds of these eight town hospitals were occupied but 46% of the time. This would ordinarily make the unit costs very high. On the contrary, they are lower. This is due to the fact that general running expenses only were reported and because certain of the improvised "residence" hospitals have practically no overhead charges. The place may be a residence also, so when the hospital use ceases, the residence use simply continues undisturbed. In other cases the very minimum of service is employed: "practical" instead of trained nurses are used, or, as in one case their service does not require the usual rate of compensation. Furthermore, the doctors seldom charge their services against the hospital account, rather against their general practice. The hospital is a means to this end, rather than a community institution rendering service in its own right.

2. Unit requirements of hospital, library, and high school compared in terms of community population, costs and service areas:

[3]Hospitals and Dispensaries: 1923, U. S. Census Bureau.

Unit Requirements and Costs Per Unit

Kinds of Institutions	Minimum Service Unit	Total Costs Per Service Unit	Population Required	Local Costs Per Capita	Service Area in Square Miles	Tax Rate on Assessed Valuation of Area for Local Costs
The High School	100 pupils	$113.00	1,250	$7.20	41.7	.0037
The Library..	30,000 book circulation	.13	4,000	1.00	133.3	.0005
The Hospital..	30 beds	4.00	6,000	2.10	200.0	.0011

3. Improving the hospital service for small communities: With hospital service in the state varying from zero in some communities to one bed for every 250 people in others, it would appear that there is opportunity for making improvements. In the eight communities studied there is only one bed for every 384 people. When just the town population is considered, there is one bed for every 124 people. Many authorities within the American Hospital Association seem to agree that one bed for about every 200 people is a reasonable goal for real community service. What are some of the problems which the farmer and the small townsman are facing in order that they may realize upon such an ideal?

First, there is the question of the country doctor, the old-time "general family physician." Modern medicine has given rise to the modern doctor, a highly trained specialist or surgeon. The older type of general practitioner is face to face with many difficulties. The newer specialist works mostly in laboratories, hospitals, or clinics. These are expensive and are often not conveniently located for the country dweller. Yet many of the more interesting and more "ready to pay" cases pass by the local doctor and go to city specialists. There are those who believe that real opportunities for a modern well-trained country doctor are very few.

Many doctors are leaving the country. Younger men are not seeeking out this field of service.[4] Statesmanship for rural life is challenged at this point. The demand must be made for an efficient health service. The services of such competent men as can act as a family counsellor, as can make a good diagnosis, or can serve the whole community as a health officer are needed. If the services of such men are to be secured, the community will need to arrange some method by which they can be well paid.

These costs will need to be spread over larger groups instead of being left to a haphazard system of "calling the doctor after the patient is flat on his back." Such doctors will need to work with other doctors at the larger centers, so that their own patients may have the benefits of laboratories and skilled surgeons. They will need to become more concerned with the problems of preventive medicine, with health campaigns, and the control of communicable diseases. But above all, the local community will need to provide these men with some facilities for working. This is the place for the general, local hospital. It should become the clinic and institution for the care of perhaps the majority of the local cases. It is futile to expect efficiency under the old system where the doctor must travel miles, going from patient to patient. Then, too, it must become the channel by which the country people can reach the modern medical laboratories and specialized hospitals where cases can be treated which are beyond the sphere of their own smaller institutions.

Second, there is the question of a local center which may stand for organized health as the school stands for systematic education. Rural communities have often been handicapped because they have no organization or institution which can gather and in turn dispense the re-

[4]Annual Report National Educational Board, "Distribution of Physicians in the United States," 1923-24, Page 20.

sources of the great medical world. The public health nurse has been one of the great modern means of help in this direction. But, like the local doctor, she cannot work alone and single-handed. She needs a local health organization. Together with the doctor she needs the local clinic and the hospital.

Not every locality can have its own institutions, but each can be a part of an organization plan which finally centers in this community hospital. This involves a system by which the local center may be related to the larger center in the nearby city or perhaps with the county institution. Legislation is available by which such hospital programs can be undertaken. In several states the county plan has been especially successful.[5] In other sections the hospital at a larger center has established relationships with hospitals in smaller towns round-a-bout. These towns are in touch with open-country health centers.[6] This allows for the specialization needed for certain cases which cannot be handled locally. But it cannot be accomplished unless there is a local hospital with its doctor who can establish these connections.

Third, the rural community should be in a position to take advantage of the state service agencies, more particularly the new Wisconsin General Hospital. This institution was made possible by an act of the Legislature passed in special session in 1920. The hospital was opened in October, 1924. It is a beautiful structure. It is complete in all its appointments for diagnosis, medical treatment, surgery, research, and for a four-year course of medical instruction. It is a public institution. It belongs to the farmer and his town. The advantage which he can take of this opportunity will depend in the long run upon the type of doctor he has in his own community. It will depend upon the kind of clinical and hospital facilities with which the doctor has to work locally. This state hospital is not designed to supplant the local hospital or the private practice of local physicians, but rather to make available, through them, the resources of the whole state, and in fact, the whole nation.

Fourth, this whole discussion involves the question of community relations in terms of roads, a center and its surrounding tributary area. It has been indicated that the unit of less than thirty beds courts many problems because its potential volume of business is too small. This means that a town and country community area having less than 5,000 to 6,000 people will do well to study carefully their needs before initiating a hospital program. Perhaps such centers might better be out-post units for the larger community center. They might have their local clinics and dispensaries, and their physicians might be related to the staff of the larger unit as has been suggested by the articles referred to above. An accumulation of small, unrelated, "strictly private," improvised units can hardly fail to produce inefficient and expensive service. Once the small community is organized and related to some hospital unit of recognized size and service, its people—farm and town folk—can avail themselves of an excellent state service.

[5]Package Library, "County Hospitals," Hospital Library and Service Bureau, 22 E. Ontario St., Chicago, Ill.

[6]Dr. Denver M. Vickers: "One Solution for Bringing Metropolitan Service to Small Communities," Transactions American Hospital Association, 26th Annual Conference, Buffalo, 1924, Vol. XXVI, P. 48.

Colds

Dr. F. Szymzak, of the Staff of St. Francis Hospital, Blue Island, Ill.

By the common cold is meant a catarrhal condition of the mucous membrane of the upper respiratory passages, its synonyms are coryza or rhinitis.

The common cold is a perennial problem to both the practitioner and the health officer. A great deal has been written on the subject and many remedies suggested, but at the present time we seem nowhere near an adequate solution. If some simple and satisfactory mode of preventing colds could be worked out a great decrease could be effected in both morbidity and mortality rates for the winter months. It is safe to say that at least 75% of all pneumonias are secondary to colds. The severe forms of bronchitis and asthma usually trace their onset to an acute coryza. Many of the more unusual infections such as meningitis, poliomyelitis, and encephalitis date their origin from an acute respiratory infection. Furthermore, it should be remembered that not only in the acute infections but also in the chronic constitutional diseases the upper respiratory passages play an important part. The first symptoms of cardiac decompensation, chronic nephritis, and diabetes often appear in the wake of a severe cold.

The common colds are of considerable importance from the economical standpoint, as it is stated in the statistical bulletin of the Metropolitan Life Insurance Co. of November, 1923, that in a group of 6,700 clerical employees, colds occurred at the rate of 420.7 per thousand for the year with a loss of 6,233 days, at an average salary of $4.00 per day the total loss for the year amounted to about $25,000.

Etiology

1. *Distribution:* Widespread in the temperate and cold regions. 2. *Seasons:* Especially at changes of temperature as in early spring and early winter. 3. *Age:* No age is immune; children are very susceptible. 4. *Bacteriology:* The healthy nasal cavity is sterile or contains at most a few staphylococci. The normal pharynx and nasopharynx, however, harbor many bacteria, the most important being the streptococcus viridans, streptococcus hemolyticus, pneumococcus, usually type IV, occasionally bacillus influenza, micrococcus catarrhalis, staphylococcus aureus and albus. The staphylococcus albus and streptococcus viridans usually predominate. In acute coryza the bacteriology of the mouth usually differs very little from that of the healthy state.

Classification of Colds

1. Non-contagious. 2. Contagious. 3. Influenza which may be endemic, epidemic, or pandemic.

1. *The Non-Contagious Cold.* The non-contagious cold may be due to any one of a number of causes. Any agent which irritates the mucus membrane of the pharyngeal or nasal mucus membrane may set up congestion which soon becomes an acute inflammation due to bacterial invasion of the injured mucus membrane. Some people develop a cold after almost any intestinal upset with manifestation of herpes, coated tongue, acute stomatitis, and roughness and congestion of the nasopharynx. Excessive smoking is another frequent cause of colds. Strangely enough, cigarettes appear to cause more irritation to the pharyngeal mucus membrane than cigars or a pipe. Irritating gases such as chlorin, bromin, etc., very quickly set up an acute congestion of the mucus membrane which will usually be followed by an acute pharyngitis or rhinitis. Extreme cold air or overheated air, particularly if too dry, often predisposes to a cold. Singers and public speakers are apt to develop pharyngitis after straining their voices. In this group must be con-

sidered the colds, infectious, but usually not contagious, which develop from local foci of infection such as tonsils and accessory sinuses. In addition to the colds which are caused by some local irritation to the mucus membrane, there is another large group of non-contagious colds which depend upon some disturbance in circulation. This type of infection is seen in neurotic individuals with vasomotor instability which renders them very susceptible to sudden changes in temperature. When the air is cold they are readily chilled. When they enter an over-heated room they break into a profuse perspiration.

2. *The Contagious Cold:* In the contagious cold the infection is exogenous. It may be some virulent bacterium, usually streptococcus or some type of influenza bacillus, more frequently it appears to be some filtrable virus which initiates the infection but which is soon replaced by secondary invaders. The non-contagious colds' infection is usually endogenous, that is, the exciting agent exists already in the nasopharynx and gains entrance to the mucus membrane through some local injury or some local change in temperature.

3. *The Influenza cold:* We have very little knowledge as to the exact etiology of this infection. We do not know that the three different forms are caused by the same virus. Considerable debate still exists whether the epidemic or pandemic forms are caused by the Pfeifer bacillus or by some filtrable virus. The Pfeifer bacillus can usually be demonstrated in the discharge of these patients and many bacteriologists look upon it as the determining factor of the epidemic influenza but Olitsky recently cultivated a filtrable virus from the patients with influenza and claims to have produced an influenza-like disease in rabbits by injecting them intratracheally with the virus.

Immunity Against Colds

In most people an attack of coryza gives a short-lived immunity of about six weeks or two months' duration. The brevity of this immunity in contrast to most infectious diseases is probably due to several factors. The infection is limited in extent; it is caused by organism of low virulence and it takes place on the surface of mucus membranes where there is little absorption of the toxic products into the system.

Prevention of Colds

Before taking up the subject of specific prophylaxis, it is necessary to emphasize certain general principles in the prevention of acute respiratory infections. In the first place it is obvious that a person should be in perfect physical condition. The diet must be regulated so that gastro-intestinal disturbances do not occur. The patient should sleep in well ventilated rooms winter and summer. The bowels should be properly regulated. Proper clothing is also very important. A careful examination should be made for infected sinuses and chronic diseases of the tonsils, such foci should be removed before any immunity with vaccines is established.

The treatment of the circulatory and nervous systems is perhaps the most important phase of the problem, for with good circulation and well regulated nervous system colds are much less likely to occur. There are three useful measures at our command—massage, baths, and exercise. Massage is valuable but expensive and comparatively few patients will be willing to employ it. Hot and cold baths are very useful. A few calisthenics, then a hot shower followed by a cold shower, give a tone to the vasomotor system. The third measure is exercise and should be preferably taken out of doors. Calisthenics, however, are valuable and should not be despised during the cold winter months when outdoor exercises are not available.

Prophylactic vaccination against colds. Having improved the patient's physical condition and having removed any possible foci of infection the physician is now justified in turning his attention to the problem of increasing the patient's resistance to bacterial infection by means of artificial immunization. This is best accomplished by autogenous vaccines, because stock vaccines rarely if ever produce immunity against colds. There are two reasons for this—one is that the bacteria contained in the stock vaccine are usually biologically unrelated to those causing the patient's infection; in the second place, stock vaccines are not usually sufficiently concentrated. After an autogenous vaccine is prepared inoculations are started at once, the first dose being 0.1 c.c. The patient receives subsequent inoculations once a week and the dose is increased 0.1 c.c. with each inoculation until a dose of 1 c.c. is reached. Thereafter 1 c.c. of vaccine is administered once a week indefinitely; as spring approaches inoculations are given at longer intervals, from ten days to two weeks; it is doubtful whether the immunity acquired during one season would be effective the following season. For this reason it is best to give the vaccine for two consecutive years; by this time the patient may have outgrown the habit of contracting colds, his mucus membrane is in a healthier state and, if he has heeded medical advice, his general physical condition is much improved. The above immunization requires a good many visits to the doctor's office, more than most patients are willing to make in order to prevent such a comparatively mild infection.

Treatment of Colds

In the medical literature are innumerable remedies for colds but none of them are absolutely satisfactory; therefore, most people, including physicians, accept coryza with certain resignation, and within certain limits allow nature to take her course. There are, however, certain fundamental principles in the treatment of colds which are accepted by all. First, rest, preferably in bed; second, diet; third, catharsis; fourth, the use of mild analgesics, such as aspirin, phenacetine, pyramidon, to relieve headache and pain in the nose and throat. The old fashioned treatment consisting of hot bath, hot lemonade, and whiskey, and a full dose of Dover's powders has still many advocates. Oftentimes attempts are made to abort colds by means of various agents such as 25% of argerol in aqueous solution. This may be used as a throat gargle and a few drops placed in each nostril by means of a medicine dropper. The congested nasal mucosa may be cocainized with 4% cocaine and shrunken down with adrenalin. Quinine given internally has still its advocates. Vaccines are useful only in the prevention of colds and in the treatment of any particular attack.

The chlorine gas treatment: Drs. Lieutenant Colonel Edward B. Vedder and Capt. Harold P. Sawyer of the U. S. army medical corps, have recently published in the March issue of the Journal of the American Medical Association an important study on the use of chlorine as a therapeutic agent in respiratory diseases. These investigators have determined that an atmosphere containing 0.021 mg. of chlorine per liter of air will kill most bacteria in one or two hours and that this degree of concentration is non-irritating to the nose and throat, and that throat cultures are almost sterile in patients who have inhaled such an atmosphere for one or two hours. Statistics quoted tend to show that by the chlorine gas treatment 74.2% of acute coryza were cured and 23.6% of the cases markedly improved. Acute laryngitis, whooping cough, influenza, acute and chronic bronchitis show about the same result. The chronic rhinitis cases seem to be somewhat rebellious. The above results were obtained from the treatment of 930 cases. There is, according to reports, very little benefit to be expected where efficient disinfection of deep-seated structures or even tonsillar crypts is desired.

St. Joseph's Hospital, Memphis, Tenn., Recruits Emergency Unit

Doctors and Nurses to Be Ready for All Calls

St. Joseph's Hospital, Memphis, Tenn., has organized an emergency unit composed of doctors and nurses on duty at the hospital. The organization is one result of the Frisco Railroad wreck at Victoria, Miss., Oct. 28, 1925, when a group of doctors and nurses left the hospital in an ambulance and administered first aid to many of the fifty-four injured in the wreck. The unit was highly commended for the service given.

The unit is now fully organized and will be ready for duty at all times. J. J. Collin's ambulance has been engaged to convey them to the place where called. Only eight minutes is required for the unit to be in readiness, after the emergency signal has been given. This unit is the first of its kind to be organized in Memphis.

EMERGENCY UNIT, ST. JOSEPH'S HOSPITAL, MEMPHIS, TENN.

The following doctors and nurses comprise the unit and will serve for one year. Doctors R. T. Smith and G. C. Rosenberg, graduate interns; Miss S. M. Scott, R. N., instructress of nurses; Misses Gladys Mitchell, Mary Sutton, and Elna Birkhead, student nurses.

The Economic Value of Centralization of Equipment and Supplies[1]

Sister M. Thomasine, St. Mary's Hospital, San Francisco

The purpose of this paper is to bring before you the benefit derived by our hospital from a centralized system of handling equipment and supplies. After operating for one year along this line, we have no hesitancy in putting forth and endorsing a similar system for any hospital which has not had the experience, for we have proven the advantages of centralization and its great necessity in a large institution. It is a time saver; it insures longevity of equipment, by keeping it in proper repair. This is accomplished by fastening the responsibility for the upkeep of the property on a given center, all conducing to the betterment of service to the patient and the economics of the institution.

We all know from experience that decentralization necessitates a duplication of various equipment and also tends to retard prompt service—so much in demand today. We are living in an age of service, and where is efficient service more necessary than in ministering to the sick? It seems, therefore, a duty incumbent on every well organized hospital to focus its attention on such an important point.

We will briefly outline some of the salient features of what we term our "Central Supply Room":

Necessity: It facilitates service, inasmuch as all necessary equipment and supplies are centralized in one place, in charge of one individual, who is responsible for the replenishing of supplies and proper upkeep of equipment. This department carries all articles used by nursing service, such as sterile and unsterile dressings, plaster, rubber goods, needles, syringes, instruments, Murphy-drip cans, etc. Equipment for minor surgical procedures is always in readiness, also aspirating sets, salt and glucose solutions, spinal punctures, hypermoclysis sets, etc.

It instills into the student nurse habits of carefulness inasmuch as she cannot help herself at random to hospital supplies. No article can be obtained except on signed requisition, so that she will carefully return same rather than pay for its destruction or loss. It also unifies hospital equipment and insures against its use for purposes other than intended.

Routine: This department must necessarily operate twenty-four hours per day and should be in charge of a graduate nurse with executive ability.

As mentioned under the previous heading, goods are distributed only on signed requisition. If equipment is dispensed the requisition is kept on file until the article is returned in good condition. The office furnishes a report on daily dismissals which enables the supply room

[1]Read at the California, Arizona, Nevada Conference of the C. H. A., Sept., 1925.

to check up, on all outstanding goods. Until goods are returned, graduate nurses are excluded from call list. If goods are given out on requisition for patient, the charge is sent to the bookkeeper on the daily financial report. Should any house property, such as blood pressure apparatus, cast cutters, etc., be mislaid or destroyed either by a graduate or a student nurse, a charge equivalent to its value is made.

Results: It will readily be seen from the foregoing that better service is the result of a centralized systematic handling of supplies and equipment. Any article can be had on a moment's notice, in good condition and always in the same place. It saves the "I thought it was there", "I was sure I had plenty of it," which so tries the patience of all concerned.

From the standpoint of the nurses' training it is most valuable. The student is taught care from the start as she knows she will be required to pay for what she handles carelessly.

The economic value to the hospital is incalculable. Supplies cannot be given out without charge. We have found that the revenue from dressings alone doubles itself. The care and conservation of rubber goods is another important item. When we began our present system, we collected all the hot water bags, ice caps and ice collars that were lying around at random. The number was sufficient to supply our need for a year. Hospital bags are no longer found in the nurses' home or the help's quarters. We are able to keep an accurate account of just how many of an article are available for use and insure their proper upkeep. One can readily see the conservation of time for the floor supervisor, who, relieved of all care of supplies and equipment other than placing an O.K. on requisitions, can give herself unstintedly to the care of the sick and the teaching of the students.

SISTER M. BRIDGET DIES AFTER BUSY LIFE

Sister Mary Bridget of the Franciscan Sisters of the Sacred Heart died on Jan. 8 at St. Joseph's Hospital, Joliet, Ill. Sister M. Bridget was 80 years of age and had been a member of her community for 59 years. She was the foundress of St. Mary's Hospital, La Salle, Ill., and of the St. Joseph's Hospital, Elgin, Ill. The first years of both these hospitals were marked with hardships, privations, and struggles.

SISTER MARY BRIDGET.

During her long service in religion, Sister M. Bridget had been a superior of St. Mary's Hospital, LaSalle, of St. Joseph's, Joliet, and of St. Joseph's, Elgin, and was loved and respected by all entrusted to her care. She was of a quiet but very active disposition. She had enjoyed good health until a month before her death when, her strength failing, she sank rapidly and breathed her last on Jan. 8, surrounded by a large number of sorrowing Sisters.

Sister M. Bridget had two nephews in the priesthood; her relatives live in Iowa and New York.

ADDITIONAL LIST OF APPROVED CATHOLIC HOSPITALS

The following Catholic hospitals escaped the notice of the Hospital Progress editorial staff when the list of Catholic hospitals approved by the American College of Surgeons was published in the January issue. The names below added to those published in January complete the list of Catholic hospitals approved for 1925. While the list has been carefully edited, omissions are possible and corrections will be gladly received and published.

Alabama
Mobile City Hospital, Mobile.
Colorado
Glockner General Hospital, Colorado Springs.
Illinois
Hospital of St. Anthony de Padue, Chicago.
Kentucky
Ashland General Hospital, Ashland.
Louisiana
Our Lady of the Lake Sanitarium, Baton Rouge.
Michigan
House of Providence, Detroit.
Old Borgess Hospital, Kalamazoo.
New Hampshire
St. Joseph's Hospital, Nashua.
New York
Anthony Brady Hospital, Albany.
Mary Immaculate Hospital, Jamaica.
Oklahoma
Ponca City Hospital, Ponca City.
Pennsylvania
Roselia Foundling Asylum and Maternity Hospital, Pittsburgh.
St. Vincent's Hospital, Philadelphia.
Texas
Santa Fe Hospital, Temple.
Vermont
Bishop de Goss Briand Hospital, Burlington.

Canada

Alberta
Vegreville General Hospital, Vegreville.
Ontario
General Hospital, Sault Ste. Marie.
Quebec
De La Misericordia Hospital, Montreal.
Saskatchewan
Providence Hospital, Moose Jaw.

Pennsylvania Conference. The fifth Annual Conference of the Pennsylvania Section of the Catholic Hospital Association will be held at Mercy Hospital, Johnstown, Pennsylvania, April 12th-13th, 1926.

St. Vincent de Paul Hospital, Brockville, Ont. The Sodality for Nurses at St. Vincent de Paul Hospital, Brockville, organized in 1925, is keeping up earnest and active work in honour of the Blessed Mother. On January 24th sixteen nurses were received into the Sodality and those who were previously admitted into the Society renewed their promises and Act of Consecration. Rev. D. O'Sullivan, C.SS.R., gave the Sodalists a most touching lecture on the Mother of God, emphasizing the special protection she would have over each and every one of the Sodality. Hymns suitable to the occasion were rendered during the ceremony.

St. Anthony's, Denver, Elects Staff Officers. Dr. Frank M. McCartney has been reelected chairman of the executive committee of St. Anthony's Hospital, Denver, Colo. Sixty-two physicians and surgeons have been appointed to staff positions in the various departments of the hospital.

New Addition Ready. The first floor of the addition to Sacred Heart Hospital, Ft. Madison, Iowa, will be ready for occupancy February 1. The opening of this new addition adds fifteen beds to the hospital. The remainder of the building will be completed soon.

Medical Mission Notes

A CATHOLIC MEDICAL MISSION IN INDIA

By Joanna Lyons, M.D.

Society of Catholic Medical Missionaries, 1000 Newton St., N. E., Washington, D. C.

A Catholic medical mission with a woman doctor, who is also a religious, at its head, should be an interesting thing to have a glimpse of.

About three hundred miles from Madras is Guntur, a "village" of some 70,000, and the center of a district of which the population is about one and a half millions. Here the Sisters of Jesus, Mary, and Joseph, a religious community founded about one hundred years ago in Holland, have a house. Although the main work of this congregation is that of education, when it opened its house in Madras it was found that medical work must of necessity be a part of the mission work. This work serves as a means of approach and meets an imperative demand of Christian charity, in a district where there are multitudes of persons deprived of the most elementary sanitary and hygienic helps and to whom the most ordinary medical aid is practically inaccessible. There is an appalling amount of abject misery to be relieved and the Sisters find many a golden opportunity of giving a passport to heaven by baptizing many a tiny sufferer who is beyond human aid.

In 1920, Sister Mary of the Sacred Heart, who is a graduate in medicine and surgery from Melbourne University, entered upon her professional duties at Guntur. She will tell you herself some details of the work being done there:

Dispensary Work

"At present the morning attendance in the dispensary averages about 200 patients, of whom many walk sixteen to twenty miles. Some patients travel 200 to 300 miles in the hope of regaining health at this sanctuary of the afflicted. Mothers walk a four days' journey carrying their sick—too often, dying—babies to the "ammagarus" for life-giving medicine.

Work Among the Children

The special work of the Sisters is among the little ones. From Guntur they visit over one hundred villages and seek out the sick children. Last year they prepared no fewer than sixteen hundred for heaven. This number may appear large, but is easily explained. The death rate, exceedingly high throughout India, is said to reach its maximum in the Guntur district. To the ordinary causes of infant mortality may be added others peculiar to Eastern lands. First among these may be reckoned the early age of marriage. Recently a woman left the Guntur Government hospital with her little daughter eight days old. Before departure she introduced her visitors, among whom was the baby's "husband", aged four years. Among Catholics the minimum age for marriage was formerly twelve years. Canon law has now fixed it at fourteen. Ordinarily the marriage takes place as soon as the girl reaches the prescribed age. Little wonder that it is the rule for these child-mothers to lose their first-born.

Sanitation and Housing

Speaking broadly, one may say that there is no sanitation whatever in India, and hygiene, public or private, is unknown.

The housing question is responsible for much of the difficulty. The people crowd together in villages. The streets, where these exist at all, are often so narrow that people must walk in single file. The houses usually consist, even when the people are in moderately comfortable circumstances, of one room only. In this, owing to the joint family system, huddle several families. Isolation of persons suffering from infectious diseases is therefore impracticable.

Water Supply

The people are, after a fashion, personally clean. Bathing is practically a religious rite and the bath—an elaborate ceremony—plays an important part on many occasions. But the people cheerfully drink water from open tanks in which their buffalos, dogs, and they themselves are accustomed to bathe. Naturally, cholera, typhoid and such infections are endemic. When cholera breaks out, no sanitary precautions whatever are taken. The marvel is that it does not devastate the whole village.

Smallpox

Smallpox is rife, despite the government's attempt to enforce vaccination. The people regard this disease as the visitation of a goddess. During the attack certain religious rites must be observed. No medicine may be given to the patient; above all, no water must touch them until peeling is far advanced; then a ceremonial bath is taken. There is no attempt to isolate the patients.

Native Remedies

The actual cautery is in great favor among the Indians. On the ninth day babies have their tiny bodies seamed with burned lines. The cautery is promptly applied and deep burns are inflicted, when convulsions or fits occur. Recovery of consciousness is counted a proof of the efficacy of the treatment.

Opium, or "black medicine" is of course well known. Mothers administer the drug to their young babies. Not infrequently it happens that these die, as their mothers express it, "from no sickness," having simply slipped from deep sleep into the deeper sleep of death.

Native quacks abound and the people place much confidence in them. Treatment is inextricably bound up with charms and invocations of gods and devils to the accompaniment of quaint strains of music from a kind of drum and an Indian flute. Strings of beads, Indian rosaries, and palmleaf books form part of the equipment.

It is common for patients to be subjected to an absolute fast extending over several weeks. The people religiously observe the imposed conditions.

Medical Work Among Women

This country presents another difficulty. Respectable women will on no account submit to examination by a medical man. In many districts Mohammedan and high caste Hindu women observe strict "gosha" or "purdah" and may not even be seen by strange men.

The government strives to meet this difficulty by affording every opportunity for women to study medicine free of charge. The Lady Dufferin Society provides in addition maintenance scholarships for women medical students. But the number remains distressingly few. According to an estimate prepared a few years ago, ninety-nine per cent of the women of India are illiterate.

Catholic Medical Missionary Women

There are at most four qualified Catholic medical missionary women among a heathen population of three hundred millions! An estimate gives the number of Protestant medical missionaries in India as four hundred and thirty-eight, of whom two hundred are women.

As to the hospital situation, Sister Mary of the Sacred Heart quotes these words of another religious:

"There are, it is true, many hospitals for women in India, at Lahore, Allahabad, Benares, Patna, Bombay, and many other places; but these are Protestant hospitals—we must recognize it to their honor. The Catholics alone are without hospitals.

Shall we, privileged children of the Catholic church, remain inactive, we who can give to pagans not only science and philanthropy, but also the true science of faith, the knowledge of the Sacraments and the means of receiving all the helps of our Holy Mother, the Church, in their last moments?"

DYING BOY WHO HAS JUST RECEIVED THE LAST SACRAMENTS AT THE ST. JOSEPH'S CONVENT, GUNTUR, INDIA.